

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04684

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		4726 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Montg</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spencerville</i>		c. LENGTH OF STAY IN TB <i>5 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spencerville</i>		d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Kirk</i>	Middle <i>Alderton</i>	Last <i>Alderton</i>	4. DATE OF DEATH <i>Apr 24</i>	Month <i>Apr</i>	Doy <i>24</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-24-1872</i>	9. AGE (in years last birthday) <i>85</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. C.</i>				
13. FATHER'S NAME <i>John Alderton</i>				14. MOTHER'S MAIDEN NAME <i>Mary Heironimus</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>#####</i>		17. INFORMANT <i>O. Hermann Alderton (son) Same as Deceased</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i>Coronary occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>b)</i>		DUE TO <i>(b)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Burtonsville</i>		(County) <i>Burtonsville</i>	(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	DATE SIGNED <i>Apr 24-1958</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>										
22a. BURIAL, CREMATION, OR BURIAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 26</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Columbia Baptist</i>		22d. LOCATION (City, town, or county) <i>Burtonsville</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Royce Barber</i>		ADDRESS <i>Laytonsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 26 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Albert Reich</i>				

BUREAU X

APR 28 1958

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4727 CERTIFICATE OF DEATH

Reg. Dist. No.

04685

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY <b>Jefferson</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>93 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charles Town</b>		d. STREET ADDRESS <b>317 South Mildred Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Lester</b>	Middle <b>Barr</b>	Last <b>Alexander</b>	4. DATE OF DEATH <b>April</b>	Month <b>Month</b>	Day <b>11</b>	Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1917</b>	9. AGE (In years less birthday) <b>41 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Herbert Lee Alexander</b>		14. MOTHER'S MAIDEN NAME <b>May Barr</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWII Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma left kidney</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Edema</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) <b>ADDRESS (Street, city or town, state)</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from <b>January 8, 1958</b> , to <b>April 11, 1958</b> , that I last saw the deceased alive on <b>April 11, 1958</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Edward W. Moore</b>		M.D.		The Clinical Center		DATE SIGNED <b>4-11-1958</b>		
PHYSICIAN'S NAME (Type) <b>Edward W. Moore, M.D.</b>				The National Institutes of Health <b>Bethesda 14, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Church Cemetery</b>		22d. LOCATION (City, town, or county) <b>Charlestown, W. Virginia</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		ADDRESS		24e. REC'D BY REGISTRAR <b>APR 14 '58</b>		24f. REGISTRAR'S SIGNATURE <b>Alfred E. Deutch</b>		

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APR 14 1989

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4728

## CERTIFICATE OF DEATH

Reg. Dist. No.

04686

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>5 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Georgia</b>		b. COUNTY		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Atlanta</b>		49X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>132 Tye Street, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Anna</b>		First	Middle	Last	Allen	4. DATE OF DEATH <b>April 4 1958</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1909</b>		9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>John A. Gaines</b>				14. MOTHER'S MAIDEN NAME <b>Addie S. Moon</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> INTERVAL BETWEEN ONSET AND DEATH <b>410X 20 Minutes</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aortic dye injection, Thoracic Aortagram</b> 21 Minutes										
(c) <b>Rheumatic Heart Disease with Mitral Stenosis</b> 3 Years										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Atlanta</b> (County) <b>Georgia</b> (State)				
21. I certify that I attended the deceased from <b>March 30, 1958</b> , to <b>April 4, 1958</b> , that I last saw the deceased alive on <b>April 4, 1958</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/5/58</b>										
ACTUAL SIGNATURE <i>James A. McFarland</i>		M.D.								
PHYSICIAN'S NAME (Type) <b>JAMES A. MCFARLAND M.D.</b>		National Institutes of Health Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>4/5/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Crest Lawn</b>		22d. LOCATION (City, town, or county) <b>Atlanta, Georgia</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Clifford L. Heath</i>				

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04688

469

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

MARYLAND

c. LENGTH OF STAY IN 1b

d. STREET ADDRESS

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First Middle

Last

4. DATE  
OF  
DEATHMonth  
4 - Day  
22Year  
1958

S. SEX

f. COLOR OR RACE

m. Widowed  d. Divorced 7. MARRIED  NEVER MARRIED 

8. B. DATE OF BIRTH

4-21-58

9. AGE (In years  
last birthday)  
yrs.10. IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August Patrick Anastasi

14. MOTHER'S MAIDEN NAME

Shirley Ann Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

762.0

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Congenital Defects  
(bilateral)INTERVAL BETWEEN  
ONSET AND DEATH20a. MEDICAL CERTIFICATION  
ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19 p. m.20d. INJURY OCCURRED  
White of work  Not white of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from April 21, 1958, to h - 22 - , 1958, that I last saw the deceased alive on April 22, 1958, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

H. H. Diamond

M.D.

8224 Georgia Avenue, S.S., Md. 4/24/58

PHYSICIAN'S  
NAME (Type)

H. H. Diamond, M.D.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
cremation22b. DATE THEREOF  
4-24-5822c. NAME OF CEMETERY OR CREMATORIUM  
Washington Sanitarium22d. LOCATION (City, town, or county)  
(State)  
Takoma Park, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Robert A. Hare, M.D., Washington Sanitarium

24a. REC'D BY REGISTRAR

APR 28 '58

24b. REGISTRAR'S SIGNATURE

H. H. Diamond

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE - BIRMINGHAM  
CERTIFICATE OF SERVICE

BUREAU V. L.

APR 28 1958

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4693

## CERTIFICATE OF DEATH

04689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tacoma Park		c. LENGTH OF STAY IN lb 4 Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Tacoma Park	
3. NAME OF DECEASED (Type or print) Dortha First Catherine Middle Lost Andrews		d. STREET ADDRESS 17717 Garland Ave	
4. DATE OF DEATH Apr Month 2nd Day Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14-1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 10 Days 18 Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Home work	
11. BIRTHPLACE (State or foreign country) Fulton Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Souders		14. MOTHER'S MAIDEN NAME Christeen Weller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Tacoma Park, Md 7717 Garland Ave	
M. Irene Showacre			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Congestive Failure		2 mo-	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma - Primary Breast (R) 5 yrs			
DUE TO (a)		DUE TO (b)	
DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1958, to <u>April 2</u> , 1958 that I last saw the deceased alive on <u>April 2</u> , 1958, and that death occurred at <u>140A</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest A. Sarao, M.D.		ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave</u>	
PHYSICIAN'S NAME (Type) ERNEST A. SARAO, M.D.		DATE SIGNED <u>4/2/58</u>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		ADDRESS <u>Gaithersburg, Md.</u>	
		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred Beach</u>	

**RECEIVED**

APR 7 1968

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4694

## CERTIFICATE OF DEATH

Reg. Dist. No.

04690

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>415 Pinehurst Ave, Licomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>29 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury, Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>		d. STREET ADDRESS <i>415 Pinehurst Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Lester</i>	Middle <i>Paul</i>	Last <i>Argenbright</i>	4. DATE OF DEATH <i>April 11 1958</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/29/95</i>	9. AGE (In years last birthday) <i>62 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Representative</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>American</i>					
13. FATHER'S NAME <i>Titus Agenbright</i>		14. MOTHER'S MAIDEN NAME <i>Sarah SKyles</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>U.S. Navy</i>		16. SOCIAL SECURITY NO. <i>304-09-4470</i>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Congestive heart failure</i>					
DUE TO					
(c) <i>Diffuse interstitial pulmonary fibrosis</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>4114</i>	(County) (State) <i>1958</i>
21. I certify that I attended the deceased from <i>4/9/58</i> , 19, to <i>4/14</i> , 1958, that I last saw the deceased alive on <i>April 11 1958</i> , and that death occurred at <i>2:20 P.M.</i> from the causes and on the date stated above.					
ADDRESS (Street, city, or town, state) <i>1711 Rhode Island Ave, N.W. Wash. D.C.</i>					
DATE SIGNED <i>April 11, 1958</i>					
ACTUAL SIGNATURE <i>James P. Mann</i>					
PHYSICIAN'S NAME (Type) <i>JAMES P. MANN M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>4-14-58</i>		22b. DATE THEREOF <i>4-14-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Central Cemetery</i>	22d. LOCATION (City, town, or county) <i>New Market</i>	(State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons Co 300 4th St NE</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>APR 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Deane</i>

BUREAU Y. S.

APR 15 1958

REGIME

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

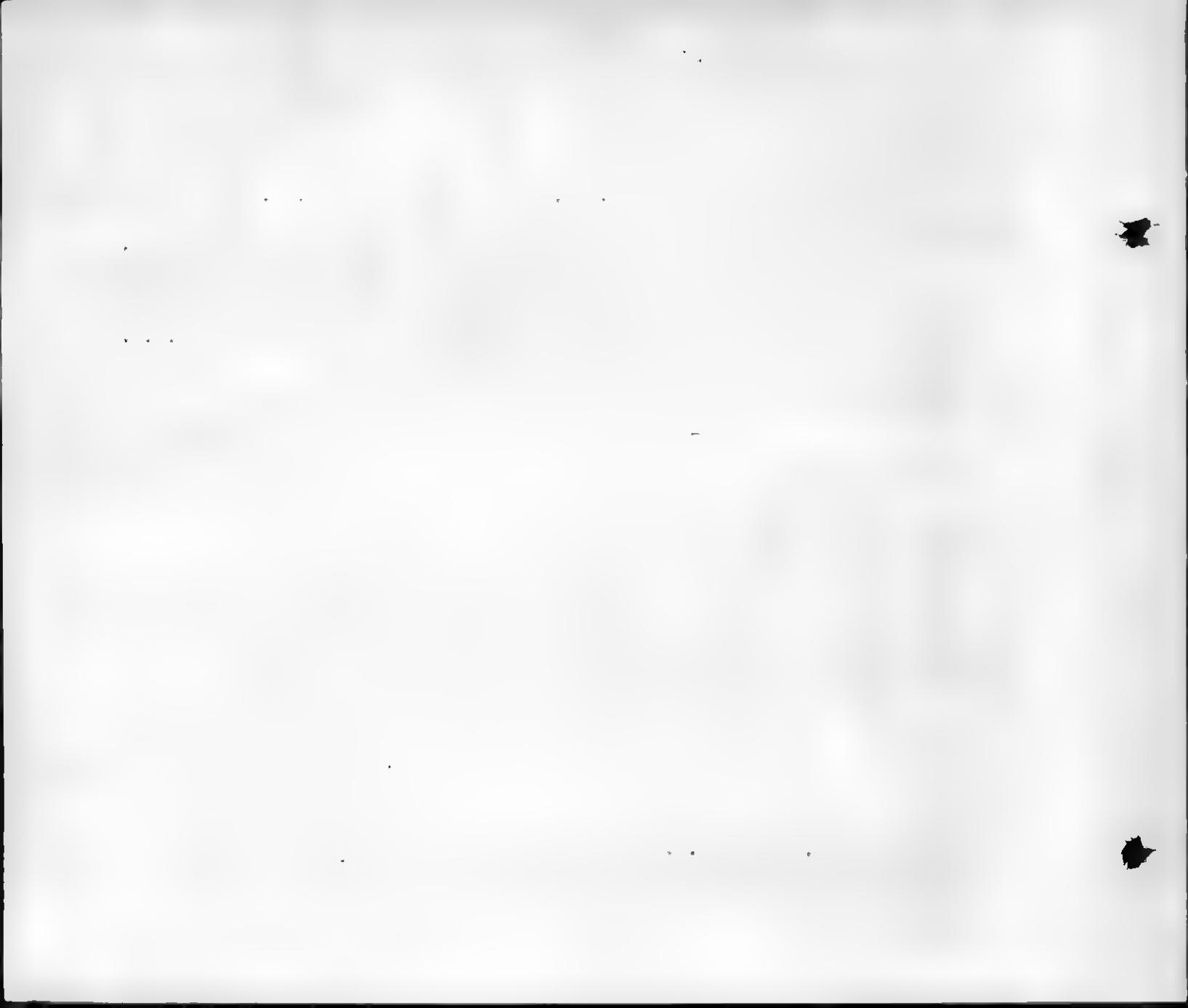
## 4729 CERTIFICATE OF DEATH

Reg. Dist. No. 04691

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 393 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Isaac	Middle Lewis	Last Armstrong	4. DATE OF DEATH Month April Day 30, Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1899		9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James Armstrong		14. MOTHER'S MAIDEN NAME Lucy Bullock		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-07-0237		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>205X</i> <i>Staphylococcal Pneumonia</i> INTERVAL BETWEEN DUE TO <i>1 month</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) <i>Mycotic Fungoides</i> 1 year (c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  4-91X					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  ADDRESS (Street, city or town, state)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 19 57, to April 30, 19 58, that I last saw the deceased alive on April 30, 19 58, and that death occurred at 11:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>Dane R. Boggs</i>	M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland				<i>4/30/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-1958		22c. NAME OF CEMETERY OR CREMATORIAL Havenwood	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Mattingly		ADDRESS 131-1628		24a. REC'D BY REGISTRAR DANE R. BOGGS MAY 5 '58	
				24b. REGISTRAR'S SIGNATURE J. W. Burchell	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4695

## CERTIFICATE OF DEATH

04692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>District of Columbia</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. LENGTH OF STAY IN lb <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington Sanitarium and Hospital</i>		d. STREET ADDRESS <i>248 Walnut St., N.W.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium and Hospital</i>				d. STREET ADDRESS <i>47...</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Owen G. Atkins</i>		First	Middle	Last	4. DATE OF DEATH <i>April 2 1958</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-1-00</i>	9. AGE (In years last birthday) <i>58 yrs</i>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock Room</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>J.C. Transit Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>Owen G. Atkins</i>		14. MOTHER'S MAIDEN NAME <i>Alberta Dalton</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>524X</i>		16. SOCIAL SECURITY NO. <i>Chart of Patient.</i>		17. INFORMANT <i>Address</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Cardiac Failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Pulmonary Fibrosis</i>		(b)				15-20 yrs		
		DUE TO <i>Extensive Pul. Anthracosis</i>				15-20 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7600 Carroll Ave., T.P.Md.</i>		20f. (City or town) <i>Prince Georges County, Md.</i>		(County) (State)
21. I certify that I attended the deceased from <i>Dec. 1957</i> , to <i>4-2-1958</i> , that I last saw the deceased alive on <i>4-2-1958</i> , and that death occurred at <i>8:08 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>7600 Carroll Ave., T.P.Md.</i>		DATE SIGNED <i>4/3/58</i>		
ACTUAL SIGNATURE <i>Robert A. Hare</i>								
PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/5/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>The B. H. Jones Co.</i>		ADDRESS <i>2901-14th St. N.W.</i>		24a. REC'D BY REGISTRAR <i>APR 7 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John E. ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 7 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4730 CERTIFICATE OF DEATH

Reg. Dist. No. 04693

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MOUNT HOWARD</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b>		c. LENGTH OF STAY IN lb <b>1-2-58-4-1-58</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVITON RD. BROOKVILLE MD.</b>		d. STREET ADDRESS <b>12 V - 5.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>AUGUSTINE P Badger</b>		First	Middle	Last	4. DATE OF DEATH <b>4</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-1863</b>	9. AGE (In years lost birthday) <b>95 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>DENTIST</b>		11. BIRTHPLACE (State or foreign country) <b>S. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>DAVID E. Badger</b>		14. MOTHER'S MAIDEN NAME <b>Adelia Lee</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>33IX</b>		16. SOCIAL SECURITY NO. DUE TO		17. INFORMANT <b>John Stappell Brookville Md</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b>		(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>CLOTHSVILLE</b>		(County) <b>CHARLES CO.</b> (State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>January 1, 1958</b> to <b>April 1, 1958</b> , that I last saw the deceased alive on <b>April 1, 1958</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D.		ADDRESS (Street, city or town, state) <b>CLOTHSVILLE</b>		DATE SIGNED <b>April 1, 1958</b>		
PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>		MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mc Clellan</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Resthaven Corp.</b>		ADDRESS <b>2244. Lakewood</b>		24a. REC'D. BY REGISTRAR APR 2 1958		24b. REGISTRAR'S SIGNATURE <b>John J. O'Farrell</b>		
				DATE				

BUKLAJ V. S.  
PACIFIC

APR 6 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04694

Reg. Dist. No. 21

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tacoma Park		d. STREET ADDRESS 7520 Carroll Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMIC, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jimmie	Middle Joe	Last BANE	4. DATE OF DEATH April	Month	Day 8	Year 1958		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1958	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME James Earl BANE				14. MOTHER'S MAIDEN NAME Patricia Ann POULSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) James E. Bane Same as #2 above			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic pneumonia, bilateral (Klebsiella) 765.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____									INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 6, 1958, to April 8, 1958, that I last saw the deceased alive on April 8, 1958, and that death occurred at 9:50 AM, from the causes and on the date stated above ACTUAL SIGNATURE <i>Jennett S. Sell</i> M.D. U.S. Naval Hospital, NNMIC DATE SIGNED 4-8-58									
PHYSICIAN'S NAME (Type) K. W. SELL, LT, MC USN Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Oakhill Cemetery		22d. LOCATION (City, town, or county) Carthage (State) Missouri			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pompey</i>		ADDRESS Wisconsin Ave., Bethesda		Md.		24a. REC'D BY REGISTRAR APR 14 '58			
						24b. REGISTRAR'S SIGNATURE <i>W. Meacham</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 {4}  
15M 10/57

BUREAU V.

173  
GEIVE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4732 CERTIFICATE OF DEATH

04695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
MARYLAND		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Etchison</b>	c. LENGTH OF STAY IN lb <b>16 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Etchison</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Gaithersburg, R.F.D. # 2</b>		d. STREET ADDRESS <b>Gaithersburg, R.F.D. # 2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Lura</b>	Middle <b>E</b>	Last <b>Bangerter</b>
4. DATE OF DEATH	Month <b>April</b>	Day <b>20</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12 1867</b>
9. AGE (In years ( month day of birth) <b>90</b> )		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Milton W. Brown</b>	14. MOTHER'S MAIDEN NAME <b>Sarah Butler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT <b>Mrs Mary L. Burke, Gaithersburg, # 2</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>			
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)			
} DUE TO			
} (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 2 1957</b> to <b>April 30 1958</b> , that I last saw the deceased alive on <b>January 15 1958</b> , and that death occurred at <b>Maryland</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>4/3/1958</b>	
ACTUAL SIGNATURE <i>James P. Kerr</i>	PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>		
22a. BURIAL, CREMATION, CREMATION (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>April 21</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) <b>Prince George Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W. Barber</i>	ADDRESS <b>Laytonsville, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 22 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Albert E. Schuck</i>

BUREAU V. S

APR 22 1981

PERIODICALS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04696

## 4733 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Monrovia</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>								e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>Herbert</b>	Middle <b>Day</b>	Last <b>Barnes</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>7</b>	Year <b>19 58</b>	
5. SEX	6. COLOR OR RACE <b>Male</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3/6/91</b>	9 AGE (in years lost birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY/ <b>U. S. A.</b>		
13. FATHER'S NAME <b>James Oliver Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Emma Day</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>220-34-0963</b>		17. INFORMANT <b>Rosa Mae Barnes</b>		Address <b>Same</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcal Pneumonia with lung abscess</b> DUE TO <b>492X</b> (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Eruptive virus infection undetermined type</b> (c) DUE TO <b>2 wks</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebro-vasc. accident 3 yrs; Generalized arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. p. m.	Month <b>19</b>	Day <b>19</b>	Year <b>1955</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>104/2/58</b>	20f. (City or town) <b>Damascus, Maryland</b>	(County) <b>Damascus</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>1955</b> , 19, to <b>4/10/58</b> , 19, that I last saw the deceased alive on <b>4/10/58</b> , 19, and that death occurred at <b>3:31 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>63 Meador, u.</b> DATE SIGNED <b>G. E. Meador, M. D.</b>								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>G. E. Meador, M. D.</b> Damascus, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 9, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Bethesda Methodist</b>	22d. LOCATION (City, town, or county) <b>Browningsville, Md.</b> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molaworth</b>	ADDRESS <b>Damascus, Md.</b>	24a. REC'D BY REGISTRAR <b>APR 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Redacted</b>				

BUREAU K

APR 9 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4734

## CERTIFICATE OF DEATH

04697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>183 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>2700 Q Street, N. W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Sara</b>	Middle <b>Katherine</b>	Last <b>Barnes</b>	4. DATE OF DEATH <b>April 22, 1958</b>	Month <b>April</b>	Day <b>22</b>	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>October 22, 1883</b>	9. AGE (In years last birthday) <b>74</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>	13. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John C. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Belinda H. Hunter</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-24-3700</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic cancer to cranium, liver, adrenals, bone</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Carcinoma of the Right Breast</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ASHD &amp; A7, Pulm. Emphysema &amp; Fibrosis</b>									
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) --		(County) --	(State) --
21. I certify that I attended the deceased from <b>October 21, 1957</b> , to <b>April 22, 1958</b> , that I last saw the deceased alive on <b>April 22, 1958</b> , and that death occurred at <b>2:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-22-58</b>									
ACTUAL SIGNATURE <b>Mitchell T. Rabkin, M.D.</b>		The Clinical Center National Institutes of Health Bethesda 14, Maryland							
PHYSICIAN'S NAME (Type) <b>Mitchell T. Rabkin, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>4/24/1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Joseph Gaumer Sons 1752 Pa. Ave. NW</b>		22d. LOCATION (City, town, or county) <b>Somerset, Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaumer Sons 1752 Pa. Ave. NW</b>		ADDRESS <b>1752 Pa. Ave. NW</b>		24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE <b>G. L. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 25 1973

REGELIVEL

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-travel permit. Give Pages 1 and 2 with the Seal of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04698

Reg. Dist. No.

4735

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
Montgomery MARYLAND		a. STATE <i>D.C.</i>	b. COUNTY <i>D.C.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Silver Spring</i>		<i>1/2 hr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>7835 Eastern Ave — off of Dr. Bell</i>		<i>Washington</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM?	
<i>1300 Clifton St. N.W.</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Augustus</i>	Middle <i>John</i>
4. SEX <i>Male</i>		5. COLOR OR RACE <i>White</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
			7. DATE OF BIRTH <i>6-10-1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Naval Gun Factory</i>	
<i>Mechanic</i>		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
13. FATHER'S NAME <i>Augustus J. Bartels</i>		14. MOTHER'S MAIDEN NAME <i>Mary Morrison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <i>Edith Bartels</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IF UNDER 1 YEAR Months <i>5</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
437. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN CONSET AND DEATH <i>4 days</i>	
(b) DUE TO		?	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <i>Washington, D.C.</i> (County) <i>D.C.</i> (State) <i>D.C.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		DATE SIGNED <i>4-15-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF <i>4/18/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> (State) <i>D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. ADDRESS <i>2901 14th St. N.W.</i> Washington 9, D.C. 24b. REC'D BY REGISTRAR <i>Apr 17 '58</i> REGISTRAR'S SIGNATURE <i>W. L. Schuch</i>	

BUREAU V. S

APR 17 1979

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4736 CERTIFICATE OF DEATH

Reg. Dist. No. 04699

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>		d. STREET ADDRESS <b>2101 16th Streets, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>KATHERINE</b>	Middle <b>W.</b>	Last <b>BASTINELLI</b>
4. DATE OF DEATH	Month <b>APRIL</b>	Day <b>8</b>	Year <b>1958</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/1862</b>
9. AGE (In years lost birthday) <b>95</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Titus Bastinelli</b>	14. MOTHER'S MAIDEN NAME <b>Mary E. Latruitte</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or date of service)	17. INFORMANT <b>Miss Barbara A. Hunsberger-Tulpehocken</b>	Address <b>19 East Germantown, Philadelphia, Pa., St.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of HAMULARY GLAND (Left)</b>			
INTERVAL BETWEEN ONSET AND DEATH			
170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>CARCINOMATOSIS</b>			
DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN. 8, 1957</b> , to <b>APRIL 8, 1958</b> , that I last saw the deceased alive on <b>APRIL 8, 1958</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry M. Hines</i>		ADDRESS (Street, city or town, state) <b>2206 SWORWY DR. Bronx, New York City</b>	
PHYSICIAN'S NAME (Type) <b>HENRY M. HINES</b>		DATE SIGNED <b>4/8/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>4/12/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>The Bronx, New York City</b>
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. ADDRESS <b>2901 14th St., N.W. Washington, D.C.</b>	24b. REC'D BY REGISTRAR DATE <b>APR 11 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>N.Y.</b>	

BUREAU V. S.

APR 11 1959

DISSEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4737

## CERTIFICATE OF DEATH

Reg. Dist. No.

04700

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] STATE <b>Pennsylvania</b>		b. COUNTY	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>15 days</b>		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Lancaster</b>		d. STREET ADDRESS <b>Box 292-A, Route #4</b>	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Kenneth</b>	Middle <b>James</b>	Last <b>Bear</b>	4. DATE OF DEATH <b>April 20</b>	Month <b>April</b>	Day <b>20</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>February 3, 1956</b>	9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE [State or foreign country] <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James E. Bear</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn Leachey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>							
an 4.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Acute leukemia</b> DUE TO DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 5, 1958</b> to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 20, 1958</b> , and that death occurred at <b>5:25 P.M.</b> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/21/58</b>							
ACTUAL SIGNATURE <b>Kurt W. Kohn</b>							
PHYSICIAN'S NAME (Type) <b>Kurt W. Kohn, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Riverview</b>		22d. LOCATION (City, town, or county) (State) <b>Lancaster Co. Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				ADDRESS <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24e. REC'D BY REGISTRAR DATE <b>APR 23 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>John L. Smith</b>							

**TO HOSPITAL** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, in any event within 72 hours after death.

RECEIVED  
BUREAU N.Y.

APR 22 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4738

## CERTIFICATE OF DEATH

04701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sugarloaf Dr.</b>		d. STREET ADDRESS <b>Sugarloaf Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Hattie Virginia Bellison</b>		First	Middle	Last	4. DATE OF DEATH <b>April 21</b>	Month	Day	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1871</b>	9. AGE (In years lost birthday) <b>86 yrs</b>	10. IF UNDER 1 YEAR Months <b>86</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Montgomery Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George W. Moxley</b>			14. MOTHER'S MAIDEN NAME <b>XXXXX Sarah Baker</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Albert Senseney, Damascus, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral-Vascular Accident</b> DUE TO <b>35IX</b>								INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Arteriosclerosis</b> DUE TO (c)								????	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 20, 1958</b> , to <b>April 21, 1958</b> , that I last saw the deceased alive on <b>April 21, 1958</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b>									
ACTUAL SIGNATURE <b>G. Meadowcroft, M.D.</b>									
PHYSICIAN'S NAME (Type)		<b>Gilcin E. Meadowcroft, M.D.</b>						<b>Damascus, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Montgomery Meth.</b>		22d. LOCATION (City, town, or county) <b>Clagettsville, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Moxley</b>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

APR

DECEMBER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04702

Items 8 &amp; 9, Film G-127

4739

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u>		4739/50-CAC. MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>9 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>		d. STREET ADDRESS <u>1700 Briggs Chaney Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1700 Briggs Chaney Road</u>				d. STREET ADDRESS <u>1700 Briggs Chaney Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Dorothy</u>	Middle <u>L.</u>	Last <u>Allen</u>	4. DATE OF DEATH Month <u>April</u>	Month <u>3</u>	Day <u>1958</u>	Year
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>2/3/1896</u>	9. AGE (in years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>59</u>	IF UNDER 24 HRS Hours <u>28</u>	Days Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRHPPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifford Allen</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Bishop</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Montgomery County General Hospital admission records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>35x Huntington's Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Huntington's Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u> DUE TO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>21550 M</u>	(County)	(State)
21. I certify that I attended the deceased from <u>Jan 3, 1958</u> to <u>April 3, 1958</u> , that I last saw the deceased alive on <u>April 3, 1958</u> , and that death occurred at <u>21550 M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Silver Spring, Md.</u> DATE SIGNED <u>4/11/58</u>							
ACTUAL SIGNATURE <u>A. D. Bonifant</u> M.D. PHYSICIAN'S NAME (Type) <u>A. D. Bonifant</u> , M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/5/58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) <u>PRINCE GEORGE COUNTY, MD.</u> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Pumphrey,</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE <u>W. L. French</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VIS A15 (4)  
15M 9/55

BUREAU K

JPR 7 1958

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04703

## 4741 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Shenandoah</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>69 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edinburg</b>		d. STREET ADDRESS <b>Box 155</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Samuel</b>	Middle <b>Lewis</b>	Last <b>Berry</b>	4. DATE OF DEATH <b>April 10, 1958</b>	Month <b>April</b>	Day <b>10</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 3, 1937</b>	9. AGE (In years last birthday) <b>20</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel W. Berry</b>		14. MOTHER'S MAIDEN NAME <b>Mildred A. Hanger</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)  DUE TO Conditions, if any, which gave rise to underlying cause (b), stating the underlying cause last. (c)  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 31, 1958</b> , to <b>April 10, 1958</b> , that I last saw the deceased alive on <b>April 10, 1958</b> , and that death occurred at <b>1:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE <i>Roger Lester</i> M.D. DATE SIGNED <b>4/11/58</b>							
PHYSICIAN'S NAME (Type) <b>Roger Lester, M.D.</b>		The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Tabor</b>		22d. LOCATION (City, town, or county) (State) <b>Middlebrook Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. D. Delling</i>		ADDRESS <b>Woodstock Va</b>		24a. REC'D BY REGISTRAR <b>231550</b>		24b. REGISTRAR'S SIGNATURE <i>John Lewis</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

APR 16 1958

DEPARTMENT OF  
THE AIR FORCE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4741

## CERTIFICATE OF DEATH

Reg. Dist. No.

04704

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the ~~burial permit~~ permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>3104 McComas Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3104 McComas Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William Porter</b>		First	Middle	Last	4. DATE OF DEATH <b>April 19 1958</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH <b>12/13/1908</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS Days <b>6</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gardner</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Drew D. Bible</b>				14. MOTHER'S MAIDEN NAME <b>Dula Collier</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-44-3406</b>		17. INFORMANT <b>Margaret Caudill</b>		Address <b>sister</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Carcinoma of larynx &amp; Paroxysm</b> (c) DUE TO (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Oct 15</b> , 1957 to <b>Apr 19 1958</b> , 19_____, that I last saw the deceased alive on <b>1955</b> , 19_____, and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Kensington, Md</b>							DATE SIGNED <b>Apr 21 1958</b>
ACTUAL SIGNATURE <b>Samuel Allen</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>Samuel Allen</b>		Kensington, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/21/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Carmel Church</b>		22d. LOCATION (City, town, or county) <b>Sunshine, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>Apr 21 1958</b>		24b. REGISTRAR'S SIGNATURE <b>DeWitt</b>			

BUREAU V. S.

29 1 1950

DEGEME

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

114705

4742

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

d. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. STREET ADDRESS

3601 Husted Drive

e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF DECEASED  
(Type or print)

Ralph W. Bissonette

First

Middle

Last

## 4. DATE OF DEATH

Month April Day 19 Year 1958

## 5. SEX

M

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

8/19/94

## 9. AGE (In years lost birthday)

63 yrs.

## 10. IF UNDER 1 YEAR

Months

## 11. IF UNDER 24 HRS

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervisor  
Statistical Dept.

## 10b. KIND OF BUSINESS OR INDUSTRY

LABOR Dept.

## 11. BIRTHPLACE (State or foreign country)

Termon

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Noble H. Bissonette

## 14. MOTHER'S MAIDEN NAME

Fannie Tallman

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

YES

(If yes, give war or dates of service)

NO

W.W.I

## 16. SOCIAL SECURITY NO.

—

—

—

## 17. INFORMANT

Friend

F. Devine Finch

3601 Husted Dr.

## Address

Chevy Chase, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

44 at

## DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.(b)  
DUE TO  
(c)

Cirrhosis

## Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Gastrointestinal hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

None

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

## 19. WAS AUTOPSY PERFORMED?

YES  NO 

## 20c. TIME OF INJURY Month, Day, Year

Hour o. m. p. m.

None - 19

## 20d. INJURY OCCURRED

While Nat while

of work  of work 

## 20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

None

## 20f. (City or town)

## (County)

## (State)

## 21. I certify that I attended the deceased from

4/11/58

## to

4/11/58

## , 1958, that I last saw the deceased

alive on

4/11/58

, 1958, and that death occurred at

9:37 AM

from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

John B. Umhoe

M.D.

5805 Conn. Ave

PHYSICIAN'S  
NAME (Type)

John B. Umhoe

Chevy Chase 15 Md.

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

4/22/58

## 22b. DATE THEREOF

Silver Spring, Md.

## 22c. NAME OF CEMETERY OR CREMATORIUM

ARLINGTON NAT'L. CEMETERY

## 22d. LOCATION (City, town, or county)

ARLINGTON, VIRGINIA

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Warren E. Humphrey

8434 91 Ave

Scootax

## ADDRESS

Silver Spring, Md.

Scootax

## 24a. REC'D BY REGISTRAR

APR 23 '58

DATE

1958

1958

1958

1958

## 24b. REGISTRAR'S SIGNATURE

John E. Humphrey

John E. Humphrey

RECEIVED  
BUREAU V. S.

APR 22 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04706

4743

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's, Rural		c. LENGTH OF STAY IN lb 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's, Rural, Dawnsontown, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Louis	Middle Libius	Last Boekhoff	4. DATE OF DEATH April	Month 13	Day 19	Year 38
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10-1876		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 11 Days 3 Hours 0 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Andrew Boekhoff		14. MOTHER'S MAIDEN NAME Harris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Reva B. Boekhoff.		Address Boyd's, RFD, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  54X		Cerebral apoplexy				INTERVAL BETWEEN ONSET AND DEATH 4 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b)		Cerebral arteriosclerosis				6 hrs		
DUE TO  (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Glenmont	(County) Maryland	
						(State) Maryland		
21. I certify that I attended the deceased from Jan 1958 to April 13, 1958, that I last saw the deceased alive on April 13, 1958, and that death occurred at 9:00 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED April 14, 1958		
ACTUAL SIGNATURE Vernon E. Martens		M.D.						
PHYSICIAN'S NAME (Type) Vernon E. Martens								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58		22c. NAME OF CEMETERY OR CREMATORIAL Glenwood		22d. LOCATION (City, town, or county) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR Date APR 16 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

BUREAU V. S.

APR 16 1979

PERIODICAL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4696

## CERTIFICATE OF DEATH

Reg. Dist. No.

114707

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>71 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green Meadows</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium &amp; Hospital</i>		d. STREET ADDRESS <i>6505 20th Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Oscar (W.H.) Braer</i>		First	Middle	Last	4. DATE OF DEATH <i>4 - 12 - 1958</i>	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-12-09</i>	9. AGE (In years last birthday) <i>48 yrs</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>			
13. FATHER'S NAME <i>Marcus Braer</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Siegel</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, print or initial) <i>No</i>		16. SOCIAL SECURITY NO. <i>138-03-3854</i>		17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Coronary Occlusion - Recurrent</i> (c)			
						INTERVAL BETWEEN ONSET AND DEATH <i>terminal</i>			
						10 weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5007 M</i>		20f. (City or town) <i>7600 Carroll Ave, Tak. Park, Md</i>		(County) <i>41018</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>Aug 1, 1954</i> to <i>April 12, 1958</i> , that I last saw the deceased alive on <i>April 11, 1958</i> , and that death occurred at <i>5007 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Robert A. Hare</i>							DATE SIGNED <i>Robert A. Hare</i>
ACTUAL SIGNATURE <i>Robert A. Hare</i>		PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>4-12-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>BETH KEHILLAH CEM.</i>		22d. LOCATION (City, town, or county) <i>PLEASANTVILLE, N.J.</i>		(State) <i>N.J.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gallberg Funeral Home</i>		ADDRESS <i>4217 9th Ave.</i>		24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>John J. Gallberg</i>			

BUREAU V. S.

83

REGULAR EO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4744

## CERTIFICATE OF DEATH

04708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY			
Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 hour		6106 Hillandale Rd.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Suburban Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Baby Boy			Brey	April	9	19	58		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 9, 1958						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
---		---		Montgomery County, Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Paul M. Brey, Jr.				Betty Mullen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Hospital Record					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
Dormaturity - 24 weeks gestation. INTERVAL BETWEEN ONSET AND DEATH 1 hour									
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)									
Premature separation of placenta 1 day.									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chevy Chase		(County) Md.	(State)
21. I certify that I attended the deceased from April 9, 1958, to April 9, 1958, that I last saw the deceased alive on April 9, 1958, and that death occurred at 7:15 p.m., from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
EXCERPT SIGNATURE Charles E. Brouse									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Suburban Hosp.		22d. LOCATION (City, town, or county) Bethesda, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. W. Schlesinger			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

100

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04709

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 days</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		d. STREET ADDRESS <i>1520 Ashford Rd.</i>		4. DATE OF DEATH Month <i>4</i>		Year <i>- 11 - 1958</i>	
3. NAME OF DECEASED (Type or print) <i>Jahanna Brew</i>		First <i>Jahanna</i>	Middle <i>(A.M.)</i>	Last <i>Brew</i>	Month <i>4</i>	Day <i>- 11</i>	Year <i>- 1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-2-72</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Ferdinand Kleinboch</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Wilk</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary congestion &amp; edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Congestive heart failure</i> DUE TO (c) <i>Hypertensive cardiovascular syndrome</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>48 hours post operative intestinal obstruction</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>24 hours post operative intestinal obstruction</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>April 7, 1958, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>None</i>		(County) <i>None</i>		(State) <i>None</i>	
21. I certify that I attended the deceased from <i>April 7, 1958</i> , to <i>April 10, 1958</i> , that I last saw the deceased alive on <i>April 10, 1958</i> , and that death occurred at <i>12:15 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eino Magi</i>		ADDRESS (Street, city or town, state) <i>918 Univ. Blvd. E., Silver Spring</i>		DATE SIGNED <i>4/14/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Trans. &amp; Burial</i>		22b. DATE THEREOF <i>4/15/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>UNION CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MILWAUKEE, WISCONSIN</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren G. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>APP 14 50</i>		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

BUREAU V.

153

SERVICE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04710

4745

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY  Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 184 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove		d. STREET ADDRESS 319 Grove Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Stanley	Middle Truman	Last Brooks	4. DATE OF DEATH April	Month 2	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1902	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zoologist		10b. KIND OF BUSINESS OR INDUSTRY Research		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stanley H. Brooks				14. MOTHER'S MAIDEN NAME Inda Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address Unascertainable The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Brachio- Bronchogenic Carcinoma (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from September 30 1957, to April 2, 1958, that I last saw the deceased alive on April 2, 1958, and that death occurred at 12:20A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dane R. Boggs,		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 4-2-58	
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-5-58		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Bladensburg	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE Albert E. Schaeffer	

RECEIVED V. S.

APR 7 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4746

## CERTIFICATE OF DEATH

Reg. Dist. No.

04711

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda - Chevy Chase</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda - Chevy Chase</b>		d. STREET ADDRESS <b>4740 Bradley Blvd. Apt. A9</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4740 Bradley Blvd. Apt. A9</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b>	Middle <b>Ellen</b>	Last <b>Brown</b>	4. DATE OF DEATH <b>April 1</b>	Month <b>April</b>	Day <b>5</b>	Year <b>1958</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1863</b>		9. AGE (In years last birthday) <b>94 yrs.</b>	10. IF UNDER 1 YEAR Months <b>3</b>	11. IF UNDER 24 HRS Days <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13. FATHER'S NAME <b>Frank Seth</b>		14. MOTHER'S MAIDEN NAME <b>Malisa (Unknown)</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mrs. Fred Hartman--same as 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>321X</b>		DUE TO <b>Cerebrovascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1015 hours</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>Cerebral arteriosclerosis</b>		(c)		?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <b>Congestive heart failure due to arteriosclerotic heart disease</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 20</b> , 1958, to <b>April 5</b> , 1958, that I last saw the deceased alive on <b>April 5</b> , 1958, and that death occurred on <b>April 5</b> , 1958, M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS (Street, city or town, state) <b>104 Chevy Chase Dr., Chevy Chase 15, Md.</b> DATE SIGNED <b>4/5/58</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Trans.</b>		22b. DATE THEREOF <b>4/9/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ht. Lebanon</b>		22d. LOCATION (City, town, or county) <b>Pittsburg, Pennsylvania</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 9 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4747 CERTIFICATE OF DEATH

04712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Damascus</b>		c. LENGTH OF STAY IN lb <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural - Damascus</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 1 Gaithersburg</b>		d. STREET ADDRESS <b>R.F.D. # 1 Gaithersburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Benjamin Alexandra Buchanan</b>		First	Middle	Last	4. DATE OF DEATH <b>April 8</b>	Month	Day	Year <b>1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 21, 1889</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crossing Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Timberville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Gidding Buchanan</b>		14. MOTHER'S MAIDEN NAME <b>Sarah C. Estep</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Wm. J. Buchanan, Ijamsville, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>		
DUE TO <b>I X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis with hypertension. (c)						10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus. Recurrent bronchial asthma.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Allergic</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Forest Oak</b>		20f. (City or town) <b>Gaithersburg, Md.</b>		(County) (State)
21. I certify that I attended the deceased from <b>January 1950</b> to <b>April 8, 1958</b> , that I last saw the deceased alive on <b>April 8, 1958</b> , and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>4/9/58</b>								
ACTUAL SIGNATURE <b>Karen Boyer</b> M.D.								
PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M. D. Druid Theatre Bldg., Damascus, Md.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Forest Oak</b>		22d. LOCATION (City, town or county) <b>Gaithersburg, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molsonth</b>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>A. L. Schuch</b>		

BUREAU Y.

APR 11 1968

REGULATED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4748 CERTIFICATE OF DEATH

Reg. Dist. No.

04713

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be referred to by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Montgomery				
Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3120 McCormas Ave., Kensington, Md.		d. STREET ADDRESS		3120 McCormas Ave.				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Lillian				Buckingham	April	10	1958			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	9. AGE (in years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2/29/78	78 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Never worked		Home		Virginia		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address						
John Buckingham		Carolone M Doman								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
No		None		Mrs. Lillian Bowen-3415 Oberon St. Kans		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)				
					INTERVAL BETWEEN ONSET AND DEATH several mo.					
					many years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
19										
21. I certify that I attended the deceased from April 9, 1958, to April 10, 1958, that I last saw the deceased alive on April 10, 1958, and that death occurred at 6:45 PM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) N.B. 9901 Cedar Lane, Bethesda 14, Md.
										DATE SIGNED 4/11/58
ACTUAL SIGNATURE <i>J. Peter Martin</i>		PHYSICIAN'S NAME (Type) J. Peter Martin, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/58		22c. NAME OF CEMETERY OR CREMATORIAL Geo. Lash. Com. Inc.		22d. LOCATION (City, town, or county) Prince George Co., Va.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland								
		24a. REC'D BY REGISTRAR APR 15 '58								
		24b. REGISTRAR'S SIGNATURE <i>Alfred E. Leach</i>								

BUREAU Y, S

APR 15 1933

PROGRESSIVE

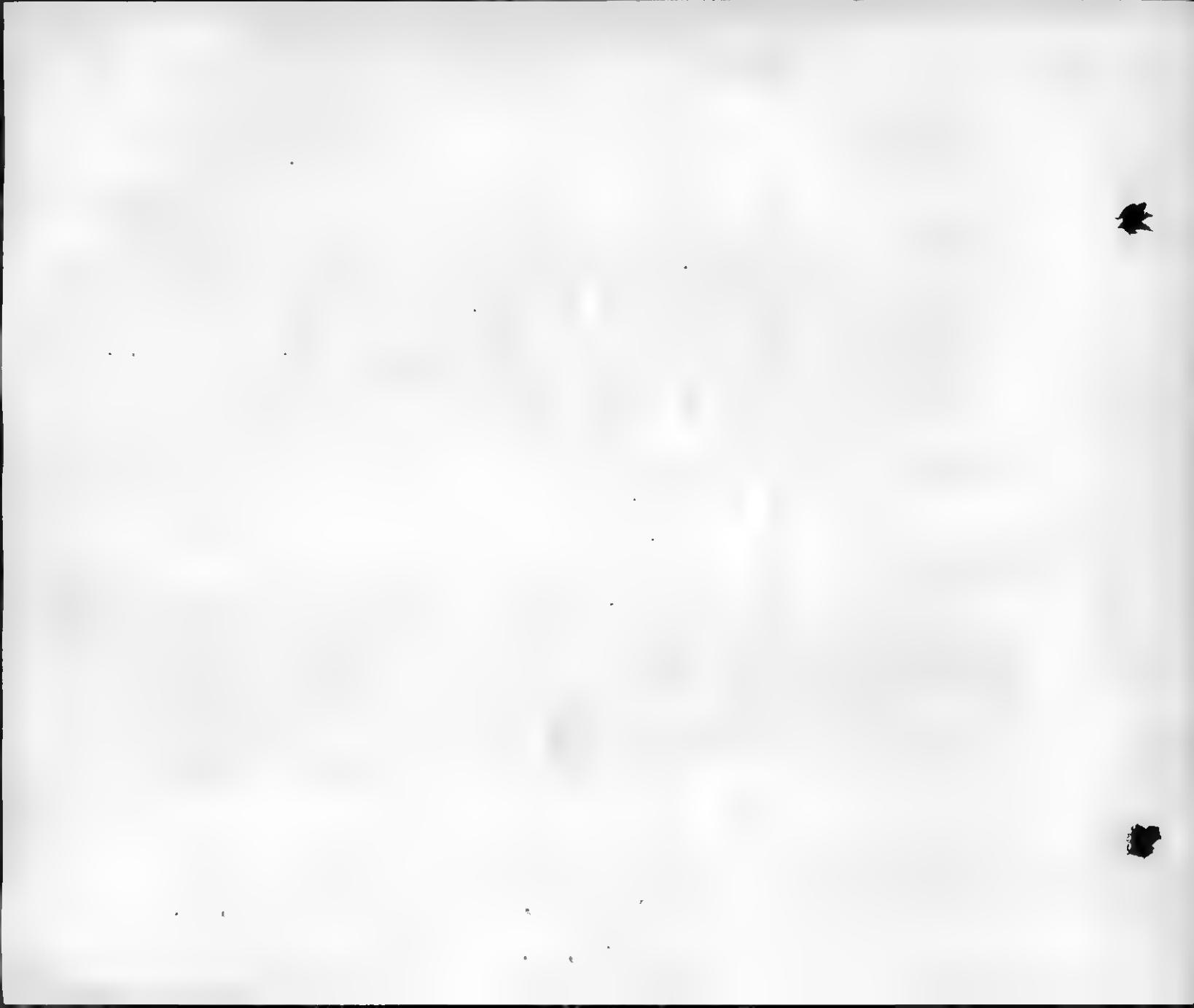
1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04714

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used on a Burial-Transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		Reg. Dist. No.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 3921 Hampton St.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		e. STREET ADDRESS <b>Kensington, Md.</b>		f. IS RES DEN. I ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ernest L. Budd</b>		First	Middle	Last	4. DATE OF DEATH <b>April 27 1958</b>	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15 1947</b>	9. AGE (In years last birthday) <b>11 yrs.</b>	IF UNDER 1 YEAR Months	Days	Hours	IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Earl Budd</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Davis</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hosp Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>bronchial obstruction</b> DUE TO (c) <b>aspiration of mucus</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>To a operation 2 hr previous to death</b>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hosp.</b>	
				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				(County) <b>Mont.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>4-29-58</b>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>									
22a. BURIAL, CREMATION, OR RECRYSTALLIZATION REMOVED <input type="checkbox"/> <input checked="" type="checkbox"/> 5/2/58		22b. DATE THEREOF <b>5/2/58</b>		22c. NAME OF CEMETERY OR CREMATORIALy <b>Ash Memorial</b>		22d. LOCATION (City, town, or county) <b>Sandy Spring, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sander</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Allie Sander</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04715

4698

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. &amp; Hospital</i>		d. STREET ADDRESS <i>431 N. Frederick Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Ella</i>		4. DATE OF DEATH Month Day Year <i>4 / 1 / 58</i>	
First <i>Ella</i>		Middle <i>Florence</i>	
Last <i>Burdette</i>			
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/18/08</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <i>49 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>David Goley</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lawson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Hts. Chart</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>191X Bilateral bronchopneumonia</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized carcinomatosis</i>			
DUE TO (c) <i>Primary grade 4 carcinoma - Cervix</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/1/58</i> , 19 <i>58</i> , to <i>4/11/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4/10/58</i> , 19 <i>58</i> , and that death occurred at <i>95A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. W. McNeill</i>		ADDRESS (Street, city or town, state) <i>1600 Carroll Ave.</i>	
PHYSICIAN'S NAME (Type) <i>W. P. McNeill</i>		DATE SIGNED <i>4/11/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/14/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Popular &amp; Private</i>		22d. LOCATION (City, town, or county) <i>f. Popular Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ella Burdette, Gaithersburg, Md.</i>		24a. REC'D BY REGISTRAR DATE APR 15 '58	
		24b. REGISTRAR'S SIGNATURE <i>A. L. Smith</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURLAU V.

PR 15 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

475

## CERTIFICATE OF DEATH

Reg. Dist. No.

04716

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>WASHINGTON</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DISTRICT OF COLUMBIA</b>		d. STREET ADDRESS <b>4200 CATHEDRAL AVE., N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ropine Nursing Home</b>				d. STREET ADDRESS <b>4200 CATHEDRAL AVE., N.W.</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lillian</b>		First <b>Lillian</b>	Middle <b>M</b>	Last <b>Calowell</b>	4. DATE OF DEATH <b>April</b>	Month <b>3</b>	Day <b>1958</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>3-9-1881</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>77</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM RANDOLPH BROWN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH DAVIS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. HAROLD E. SHEFFERS</b> , SAME AS # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b>		<b>Cerebral VASCULAR Accident</b>				<b>15 mo.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <b>Generalized Arteriosclerosis</b>				<b>10 yrs</b>	
DUE TO							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>Arteriosclerotic Heart Disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>57</b> , to <b>April 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 2</b> , 19 <b>58</b> , and that death occurred at <b>8:05 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Lewis H. Biben</b> M.D. <b>April 3, 1958</b> PHYSICIAN'S NAME (Type) <b>LEWIS H. BIBEN</b> ADDRESS <b>900 17TH ST N.W. Washington DC.</b>		ADDRESS (Street, city or town, state) DATE SIGNED					
22a. BURIAL, CREMATION, OTHER (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/8/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l.Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley, Jr.</b>		ADDRESS <b>1756 Pa. Ave., N.W. DC</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Releasch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X

APR 7 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 F11-6228 5-12-58 et  
4751 CERTIFICATE OF DEATH

Reg. Dist. No.

114717

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Florida</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>Suburban</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> 113 16th St. Petersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	d. STREET ADDRESS <i>113 16th St. Petersburg</i>		
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Caldwell</i>	Last <i>4</i> Month <i>30</i> Day <i>1958</i> Year
4. DATE OF DEATH	Month <i>4</i>	Day <i>30</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 29 1882</i>
9. AGE (in years lost birthday) <i>75 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Schoolteacher Retired Teaching Classes</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>U.S.A</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	14. PARENT'S NAME <i>James Knox Caldwell</i>	15. MOTHER'S MAIDEN NAME <i>Laura Winter</i>	Address <i>4693 Falls Rd Bethesda</i>
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>	17. SOCIAL SECURITY NO. <i>262-425-357</i>	18. INFORMANT <i>Daughter - Mrs. Marianne Peters</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Infarction</i> DUE TO <i>465X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pulmonary embolism</i> DUE TO (c)			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of prostate</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>April 30 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>St. Petersburg, Florida</i>
21. I certify that I attended the deceased from <i>26 April 1958</i> to <i>30 April 1958</i> , that I last saw the deceased alive on <i>30 April 1958</i> , and that death occurred at <i>5:50 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Arthur J. Wilets M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit 5/1/58</i>		22b. DATE THEREOF <i>5/1/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Memorial Park</i>
22d. LOCATION (City, town, or county) <i>St. Petersburg, Florida</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey Bethesda, Md.</i>		24a. ADDRESS <i>Robert A. Pumphrey Bethesda, Md.</i>	24b. REC'D BY REGISTRAR <i>DATE MAY 5 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>Av. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04718

## 4752 CERTIFICATE OF DEATH

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>45 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b></b>	Last <b>CALLAN</b>
4. DATE OF DEATH <b>April 9 1958</b>	Month <b>April</b>	Day <b>9</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-82</b>
9. AGE (In years last birthday) <b>75 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>	11. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	12. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
13. FATHER'S NAME <b>Bartholomew CALLAN</b>	14. MOTHER'S MAIDEN NAME <b>Margaret HARRIGAN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>Yes Spamer-WWI</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>(Sister) Mrs. Margaret G. Carter, same as #2</b>	Address <b></b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stomach Ulcer with Acute massive Hemorrhage</i> DUE TO <i>(post operative)</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 27, 1958</b> , to <b>April 9, 1958</b> , that I last saw the deceased alive on <b>8 April, 1958</b> , and that death occurred at <b>7:00A M</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>R. P. DOBBIE, JR.</i>	M.D. <b>U. S. Naval Hospital, NNMC</b>		ADDRESS (Street, city or town, state) <b>4-9-58</b>
PHYSICIAN'S NAME (Type) <b>R. P. DOBBIE, JR., CDR, MC, USN</b>	DATE SIGNED		
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-12-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>	ADDRESS <b>3821 14th St., NW, Wash. DC</b>	24a. REC'D BY REGISTRAR <b>APR 14 58</b>	24b. REGISTRAR'S SIGNATURE <i>Givreuch</i>

BUREAU V.

APR 14 1928

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04719

## 4753 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland</i> <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b RURAL and give nearest town)	b. COUNTY	
<i>Bethesda</i>	<i>2 hrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Suburban Hospital</i>		<i>Brookside Hosp. Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Baby "A"</i>	Middle <i>Campbell</i>	Last <i>4</i>
4. DATE OF DEATH	Month <i>9</i>	Day <i>19</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-9-58</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS Days <i>2</i>	12. IF UNDER 24 HRS Hours <i>Min</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME	
<i>William Edward Campbell</i>		<i>Pauline Roberta Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <input type="checkbox"/> INFORMANT	
<i>—</i>		<i>Mother</i>	
17. ADDRESS		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i>		DUE TO <i>Immaturity</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Fetal Atelectasis</i>	
(c)		DUE TO <i>Twinning</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Bethesda</i> (County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>4/19/58</i> , 19..., to <i>4/19/58</i> , 19..., that I last saw the deceased alive on <i>4/19/58</i> , 19..., and that death occurred at <i>10A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>809 Viers Mill Rd. Rockville Md.</i>			
ACTUAL SIGNATURE <i>James S. Stanton</i>		DATE SIGNED <i>4/21/58</i>	
PHYSICIAN'S NAME (Type) <i>Dr James S. Stanton</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>4/19/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Suburban Hosp.</i>		22d. LOCATION (City, town, or county) <i>Bethesda, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Stanton</i>		24a. REC'D BY REGISTRAR DATE <i>APR 21 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>John J. Stanton</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be referred to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be delivered to the funeral director. Page 3 should be detached for use as the burial-trust permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 21 1958

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4754

## CERTIFICATE OF DEATH

Reg. Dist. No.

04720

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be referred by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 1 hr 40"		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silva Spring				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. STREET ADDRESS Lord Hope Rd		f. DATE OF DEATH Month 4 Day 9 Year 1958		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Baby	Middle "B"	Last Campbell	4. DATE OF DEATH Month 4 Day 9 Year 1958	Month	Day	Year	
5. SEX M	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-58	9. AGE (In years lost birthday) yrs. 1 yrs.	10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	11. IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Edward Campbell		14. MOTHER'S MAIDEN NAME Pauline Roberta Williams						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Mother		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
DUE TO Conditions, if any, which gave rise to immediate cause (a), sloping the underlying cause lost. (b)								
DUE TO Twinning (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/9/58, 19, to 4/9/58, 19, that I last saw the deceased alive on 4/9/58, 19, and that death occurred at 10:05 AM, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) DATE SIGNED James S. Stanton M.D. 809 Viers Mill Rd Rockville Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4/11/58		22c. NAME OF CEMETERY OR CREMATORIUM Suburban Hosp.		22d. LOCATION (City, town, or county) (State) Bethesda, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE A. Deasech		

BUREAU X-5

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4755 CERTIFICATE OF DEATH

04721

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		Virginia	
Bethesda (Rural)		30 mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				Alexandria	
U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS	
				3832 Florence Drive, Apt. 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	Last CARLTON	4. DATE OF DEATH April 20
S. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 20, 1958	Month Year Day 1958
9. AGE (In years lost birthday) yrs 30		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Martin Edward CARLTON		14. MOTHER'S MAIDEN NAME Pauline Teresa YANCY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Martin E. Carlton, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES	
X		Prematurity DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20, 1958, to April 20, 1958, that I last saw the deceased alive on April 20, 1958, and that death occurred at 4:42A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC DATE SIGNED 4-20-58	
ACTUAL SIGNATURE <i>D. Shuptar</i>					
PHYSICIAN'S NAME (Type) D. SHUPTAR, LT, MC, USN		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. A. Pumphrey		ADDRESS 1517 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '58 24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

BUREAU V. S.

APR 22 1953

REGISTRY

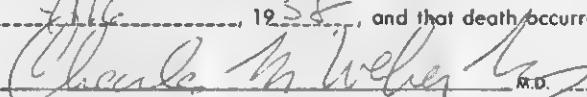
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14722

4756

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kensington</b>		d. STREET ADDRESS <b>3816 Kayson Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Estelle</b>	Middle <b>CARRIGAN</b>	Lost	4. DATE OF DEATH <b>April 17</b>	Month <b>17</b>	Day <b>19</b>	Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1884</b>	9. AGE (in years less birthday) <b>73</b> yrs.	IF UNDER 1 YEAR <b>7 months</b>	IF UNDER 24 HRS. <b>20 days</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Columbia, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Spence</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Price</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William Brassel-Same Item #2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>		<b>Acute HEART failure</b>		INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO		(c)		<b>Coronary Occlusion</b>					
(c)				<b>A.S.C.L.D</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Charlotte</b>		(County) <b>North Carolina</b>	(State) <b>USA</b>
21. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>April 16, 1958</b> , that I last saw the deceased alive on <b>April 16, 1958</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Charlotte, North Carolina</b>							DATE SIGNED <b>April 17, 1958</b>
ACTUAL SIGNATURE 		M.D.							
PHYSICIAN'S NAME (Type) <b>Charles M. Weber, M.D.</b>		10620 Georgia Ave. Wheaton, S. S. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Trans</b>		22b. DATE THEREOF <b>4/18/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elmwood</b>		22d. LOCATION (City, town, or county) <b>Charlotte</b>		(State) <b>North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>7557 Wis. Ave. Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 18 '58</b>		24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGULUS

APR 18 1958

REGULUS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04723

## 4757 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>186 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>829 Chillum Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Michael</b>	Middle <b>James</b>	Last <b>Caruso</b>	4. DATE OF DEATH <b>April 26, 1958</b>	Month <b>April</b>	Day <b>26</b>	Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1950</b>	9. AGE (In years last birthday) <b>8 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or Foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James V. Caruso</b>				14. MOTHER'S MAIDEN NAME <b>Mildred Ambrose</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO <b>Gastrointestinal Hemorrhage &amp; Intracerebral Hemorrhage.</b> Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <b>Acute Myelogenous Leukemia</b> (c)									
INTERVAL BETWEEN ONSET AND DEATH									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hemolytic Staphylococcus Aureus coagulase positive Pseudomembranous Enterocolitis.</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Enterocolitis.</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington, D. C.</b>		(County) <b>District of Columbia</b>	(State) <b>D.C.</b>
21. I certify that I attended the deceased from <b>October 22, 1957</b> to <b>April 26, 1958</b> , that I last saw the deceased alive on <b>April 26, 1958</b> , and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>									
ACTUAL SIGNATURE <i>Dane R. Boggs</i>		M.D.		DATE SIGNED <b>4/26/58</b>					
PRINTING'S NAME (Type) <b>DANE R. BOGGS, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-29-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		(State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		ADDRESS <b>3821-14th N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>APR 28 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>			

SUREAU X.

APR 5 3 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4758 CERTIFICATE OF DEATH

04724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Virginia</b>		C. COUNTY <b>Fairfax</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>74 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		d. STREET ADDRESS <b>8 - x - 1015 Taney Avenue</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First <b>Kevin</b>	Middle <b>Thomas</b>	Last <b>Collins</b>	4. DATE OF DEATH <b>April 5 1958</b>	Month Day Year	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>18 September 1957</b>	9. AGE (In years last birthday) yrs. <b>6 17</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS Days <b>17</b>	Hours <b>5</b>	Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles W. Collins</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Franklin</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>none</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> 2 - Died DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Infantile progressive Spinal Muscular Atrophy.</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 147											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>21 January, 1958</b> , to <b>5 April, 1958</b> , that I last saw the deceased alive on <b>5 April, 1958</b> , and that death occurred at <b>2:30p M</b> , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <i>Andrew S. Engel</i>				M.D.				DATE SIGNED <b>4/6/58</b>							
PHYSICIAN'S NAME (Type) <b>ANDREW S. ENGEL M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Elliptic</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>National Cemetery Arlington</b>		22d. LOCATION (City, town, or county) <b>Virginia</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Murphy</i>		ADDRESS <b>3524 Columbia St.</b>		24a. REC'D BY REGISTRAR <b>Art 4 Va</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>		DATE APR 9 '58							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 9 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

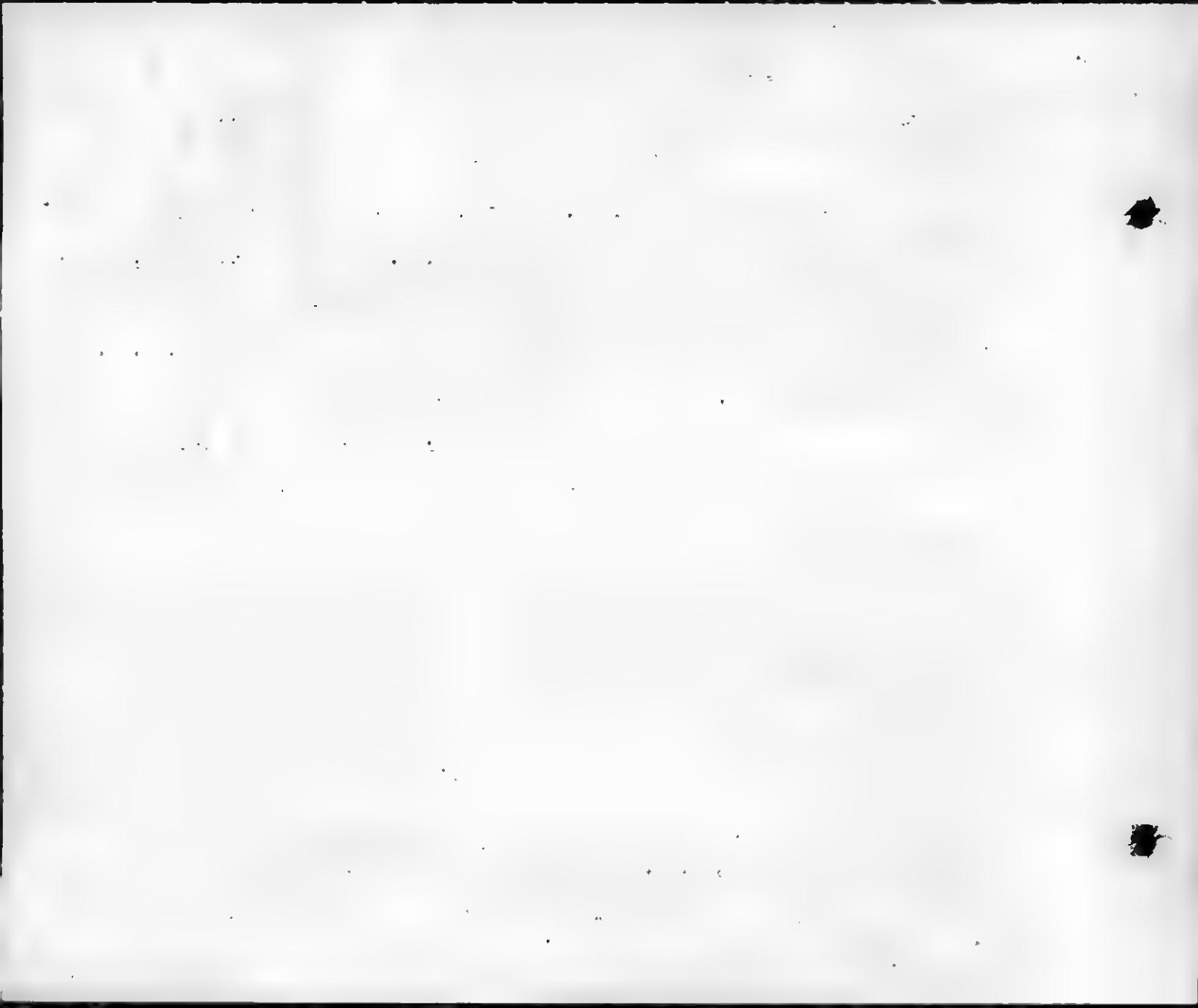
04725

4759

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>118 days</b>		a. STATE <b>Maryland</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>Seven Locks Road Box 205</b>		b. COUNTY <b>Montgomery</b>					
3. NAME OF <b>Woodrow</b> (Type or print)		First <b>Woodrow</b>	Middle <b>Lee</b>	4. DATE OF DEATH <b>Collins, Jr.</b>	Month <b>April</b>	Day <b>30,</b>	Year <b>19 58</b>		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>September 20, 1940</b>	9. AGE (In years last birthday) <b>17 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Woodrow Lee Collins, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Monard</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170.9</b>		DUE TO <b>Malignant Melanoma</b>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville</b>		(County) <b>Maryland</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>January 2, 1958</b> , to <b>April 30, 1958</b> , that I last saw the deceased alive on <b>April 30, 1958</b> , and that death occurred at <b>3:15 A M</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
ACTUAL SIGNATURE <i>Roger Lester</i>		M.D.		DATE SIGNED <b>4/30/58</b>					
PHYSICIAN'S NAME (Type) <b>Roger Lester, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/3/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Rockville</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <b>Bethesda 14, Maryland</b>		24a. REC'D. BY REGISTRAR DATE <b>MAY 5 '58</b>		24b. REGISTRAR'S SIGNATURE <i>John E. Green</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04726

## 4699 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>40 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>5701 Jomestown Rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ELSIE</i>	Middle <i>MARION</i>	Last <i>COOMBE</i>	4. DATE OF DEATH <i>April</i>	Month <i>14</i>	Day <i>1958</i>	Year
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/20/98</i>	9. AGE (In years lost birthday) <i>59 yrs</i>	IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS Days <i>9</i>	Hours <i>Min</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Posey</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Hosp Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary thrombosis</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 6826 Riggs Rd. Hyattsville Md 4/14/58	20f. (City or town) <i>Hyattsville</i>	(County) <i>Md</i>
21. I certify that I attended the deceased from <i>May 20</i> , 19 <i>57</i> to <i>April 14</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 14</i> , 19 <i>58</i> , and that death occurred at <i>9:40A</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. Wayne Clockfield</i> ADDRESS (Street, city or town, state) <i>M.D. 6826 Riggs Rd. Hyattsville Md 4/14/58</i> DATE SIGNED <i>4/14/58</i>							
PHYSICIAN'S NAME (Type) <i>H. WAYNE CLOCKFIELD</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>					
22a. BURIAL, CREMATION, DISPOSAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/17/58</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Ganech's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>APR 16 '58</i>	
						24b. REGISTRAR'S SIGNATURE <i>Al. Beuch</i>	

BUREAU X, L

APR 16 1958

RECEIVED

"AIRCRAFT  
MANUFACTURERS  
ASSOCIATION"

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04727

## 4760 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Norfolk</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>61 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>		d. STREET ADDRESS <b>419 West Olney Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Betty</b>	Middle <b>Lee</b>	Last <b>Cook</b>	4. DATE OF DEATH <b>April 10, 1958</b>	Month <b>April</b>	Day <b>10</b>	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 14, 1936</b>	9. AGE (in years (at birthday) <b>21</b> yrs.)	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas F. Castell</b>				14. MOTHER'S MAIDEN NAME <b>Maybelle Fann</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>256-52-8338</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]								
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO <b>2043</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE MYELOGENOUS LEUKEMIA</b> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute Renal failure, starvation</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
MEDICAL CERTIFICATION								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>February 8, 1958</b> to <b>April 10, 1958</b> , that I last saw the deceased alive on <b>April 10, 1958</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Richard K. Shaw, M.D.</b>							ADDRESS (Street, city or town, state) <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>Richard K. Shaw, M.D.</b>							DATE SIGNED <b>4-11-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/11/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM —		22d. LOCATION (City, town, or county) <b>Marietta</b> (State) <b>Ga.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Inc.</b>		ADDRESS <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>A. Sherrill</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURZAU V. S.

10. 11. 1958

BRUNNEN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4761 CERTIFICATE OF DEATH

04728

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <b>Virginia</b>		b. COUNTY <b>Campbell</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>119 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lynchburg</b>		d. STREET ADDRESS <b>2705 Memorial Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>Benjamin</b>	Last <b>Craft Jr.</b>	4. DATE OF DEATH <b>April</b>	Month <b>5</b>	Day <b>19</b>	Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 September 1920</b>	9. AGE (In years last birthday) <b>37</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John B. Craft Sr.</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>224-14-4882</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Pulmonary Insufficiency</b> DUE TO (c) <b>Malignant Melanoma with widespread metastasis</b> 5 years INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>7 December</b> , 19 <b>57</b> , to <b>5 April</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5 April</b> , 19 <b>58</b> , and that death occurred at <b>9:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>Edward W. Moore, M.D.</b> <b>4-5-58</b>								
ACTUAL SIGNATURE <i>Edward W. Moore</i> M.D.								
PHYSICIAN'S NAME (Type) <b>Edward W. Moore, M.D.</b> National Institutes of Health Bethesda 14, Maryland								
22a. BURIAL, CREMATION, BURIAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/7/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Hill Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Lynchburg, Virginia</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

223 - 27 1989

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4762 CERTIFICATE OF DEATH

04729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linden rural Silver Spring</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sewell's Maternity Hosp.</b>		d. STREET ADDRESS <b>1 2704 Garfield Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	Baby Girl	First	Middle	Last	4. DATE OF DEATH Month April 18 Day Year 1958	Month	Day	Year
5. SEX female	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 58</b>	9. AGE (In years last birthday) yrs <b>10</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>10</b> Minutes <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Sewell's Maternity Hosp</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John B. Craig</b>		14. MOTHER'S MAIDEN NAME <b>Earlise Teresa Williams</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>mother</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atalactasis Intox. Wern. Brauerosis</b> '76.0.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Diarrach Epidermis</b> (c) <b>Undetermined at this time Placental Infection</b>						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) <b>No amniotic fluid but thick faecal fluid</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 17, 1958</b> , to <b>April 18, 1958</b> , that I last saw the deceased alive on <b>April 18, 1958</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <b>Webster Sewell, M.D.</b>						DATE SIGNED <b>4/18/58</b>		
PHYSICIAN'S NAME (Type)		22b. DATE THEREOF <b>4-25-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lincoln Park</b>		22d. LOCATION (City, town, or county) <b>Rockville, Md.</b>		
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. REC'D BY REGISTRAR <b>MR. B. O. '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. K. Keenrich</b>				
22g. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden - Rockville, Md.</b>		ADDRESS <b>20943 20 X V4</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician has been signed by the attending physician and completely filled in by the funeral director. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and destroy them within 72 hours after death.

RECEIVED V. S

APR 22 1970

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4763 CERTIFICATE OF DEATH

04731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	c. LENGTH OF STAY IN 16 <i>Life</i>	b. COUNTY <i>Montgomery</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery County General</i>	d. STREET ADDRESS <i>400 Grandin Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clarence Henry Curtis</i>	First <i>C</i>	Middle <i>A</i>	Last <i>April 10 1958</i>
4. DATE OF DEATH <i>April 10 1958</i>	Month <i>April</i>	Day <i>10</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/27/1877</i>
9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Cathedral Guard</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>No SA.</i>
13. FATHER'S NAME <i>William Henry Curtis</i>	14. MOTHER'S MARRIED NAME <i>Sally Jones</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Ruby Curtis 400 Grandin Ave.</i>	Address <i>Rockville Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>451X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>by exanguination</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Ruptured Abdominal Aneurysm</i> <i>years</i> <i>Arteriosclerotic Vascular Disease</i> <i>Years</i>			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/10</i> , 19 <i>58</i> , to <i>4/10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4/10</i> , 19 <i>58</i> , and that death occurred at <i>5:35 PM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Rockville - Md.</i> DATE-SIGNED <i>4/10/58</i>		
ACTUAL SIGNATURE <i>Arthur E. Woodward</i>	M.D.		
PHYSICIAN'S NAME (TYPE) <i>Arthur E. Woodward</i>	Rockville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/13/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Pot. Meth. Church</i>	22d. LOCATION (City, town, or county) (State) <i>Potomac, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Fumphrey Bethesda, Maryland</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>PH 14 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John ... eber</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y, 2

... 2 14 10-3

REGISTRATION  
NUMBER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114732

Reg. Dist. No.

4764

## CERTIFICATE OF DEATH

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**CO-FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. COUNTY			
Bethesda				Bethesda					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		SUBURBAN		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
SUBURBAN		5506 Lincoln St.							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
WILLIAM		ZACK	DARCEY		APRIL	13	1958		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
MALE		white		MARCH 9 1889	70	4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Nail Carrier		U.S.Govt.-Retired.		MARYLAND		U.S.A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
WILLIAM JOSEPH DARCEY		ADA BLUNDON							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address 5506 Lincoln St. Bethesda, d.			
NO		None		Wife Sarah May Darcey					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		myocardial infarction				15 min.			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO							
(b) coronary heart disease									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
19									
21. I certify that I attended the deceased from Oct 1954, to April 1958, that I last saw the deceased alive on April 1958, and that death occurred at 320 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. M. Wynn</i>						ADDRESS (Street, city or town, state) 7659 Old Georgetown Rd., Bethesda, Maryland		DATE SIGNED Apr. 13, 1958	
PHYSICIAN'S NAME (Type)		JOHN M. WYMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/58		22c. NAME OF CEMETERY OR CREMATORIUM Hermon Cemetery		22d. LOCATION (City, town, or county) Bethesda, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 15 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

VS A15 (4)  
15M 9/55

BURLAU Y.

APR 15 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11733

Items 2,8,9&amp;14 G228 5/5/58 Ge

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in every event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <b>Ohio</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ada</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. STREET ADDRESS <b>Route #3</b>		d. STREET ADDRESS <b>Route #3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Donald Watson</b>		First <b>Donald</b>	Middle <b>Watson</b>	Last <b>DAVIS</b>	4. DATE OF DEATH <b>April 11 1958</b>	Month <b>April</b>	Day <b>11</b>	Year <b>1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/96</b>	9. AGE (in years lost birthday) <b>61 59 yrs</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS Days <b>28</b>	Hours <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College Professor</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harry W. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>Heilen</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI &amp; WWII</b>		
				17. INFORMANT <b>Not known (Wife) Jeanette B. Davis, same as #2 above</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>mouth &amp; oro-pharynx with multiple bone metastases</b>		Carcinoma, squamous cell, floor of mouth & oro-pharynx with multiple bone metastases		DUE TO and cerebral metastases.		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m p. m <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>March 16, 1958</b> , to <b>April 11, 1958</b> , that I last saw the deceased alive on <b>April 11, 1958</b> , and that death occurred at 2:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>4-11-58</b>		
ACTUAL SIGNATURE <i>Joseph R. Connelly</i>		PHYSICIAN'S NAME (Type) <b>J. R. CONNELLY, CAPT, MC, USN</b>		U. S. Naval Hospital, NMNC				
22a. BURIAL, CREMATION 22b. DATE THEREOF REMOVAL (Specify) <b>Burial 4-11-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ada</b>		(State) <b>Ohio</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		ADDRESS Bethesda, Md. <b>R. A. Pumphrey Funeral Home 7557 Wisconsin Ave</b>		24a. REC'D BY REGISTRAR <b>APR 14 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Abel Sauck</i>		

BUREAU V. 8

APR 14 1962

BUREAU V. 8

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

704734

4723

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmore Ave. Rockville, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Rev. James W.	Middle Davis	4. DATE OF DEATH April 12 Month Day Year 1958			
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1885 72 9. AGE (In years last birthday) yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (State or foreign country) Maryland.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME William Davis		14. MOTHER'S MAIDEN NAME Mary Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO				
17. INFORMANT Mrs Agnes Davis		Address 807 Westmore Ave, Rockville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260 X Diabetic & Renal Coma, Terminal Bacteremia 12 days.						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Herpes Zoster, Polyneuritis, Decubitus						
DUE TO (c) Diabetes Mellitus						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ischiorectal Abscess.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Norbeck, Rt. 1	(County) Silver Spring, Md.	(State)
21. I certify that I attended the deceased from Aug. 5, 1956 to April 12, 1958, that I last saw the deceased alive on April 11, 1958, and that death occurred at 3:50A M, from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Webster Sewell</i> ADDRESS (Street, city or town, state) 41358 DATE SIGNED M.D. Norbeck, Rt. 1 Silver Spring, Md.						
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/14/58	22c. NAME OF CEMETERY OR CREMATORIUM Fishermens.,	22d. LOCATION (City, town, or county) (State) Lincoln Park, Rockville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Harwden</i>		ADDRESS Rockville, Md.	24a. RECD BY REGISTRAR DATE APR 17 '58	24b. REGISTRAR'S SIGNATURE <i>Quinton</i>		

BUREAU V. S.

1970



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04735

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.,</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>1 yr. 6 mos.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Pr. Georges</b>			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b>					
						d. STREET ADDRESS <b>6508 Queens Chapel Rd.</b>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>SALLIE</b>		Middle <b>ETTA</b>		Last <b>DAVIS</b>		4. DATE OF DEATH <b>April</b>	Month <b>9</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 11, 1866</b>		9. AGE (in years last birthday) <b>91</b>	10. UNDER 1 YEAR Months <b>0</b>	11. UNDER 24 HRS Days <b>0</b>	12. UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Montgomery Co., N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>James Haywood</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann McDonald</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Sara E. Pridgen 6508 Queens Chapel Rd.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>192 X</b>		DUE TO <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>b.</b>		DUE TO <b>Cerebral arteriosclerosis</b>		<b>13 yrs</b>					
		c. <b>Generalized arteriosclerosis</b>				<b>26 yrs</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>After a stroke heart disease</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Colmar Manor, Pr. Geo. Co., Md.</b> (County) <b>Colmar Manor, Pr. Geo. Co., Md.</b> (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Walter J. Willett</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10 April 58</b>	
EXAMINER'S NAME (Type)		22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 12, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Pr. Geo. Co., Md.</b>		(State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., Inc., Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>Alfred L. Smith</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred L. Smith</b>		DATE <b>APR 14 '58</b>					

WILAYA V. 3

1959

CE A.C.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6, 8 & 9 Film G229 5/26/58 fcv  
4767 CERTIFICATE OF DEATH

04736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Emery Grove</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Arthur</b>	Middle <b>Sylvester</b>	Last <b>Day</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>23</b>	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/83 92</b>	9. AGE (In years lost birthday) <b>76 5 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Days <b>65</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis Day</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dickerson</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Irene Duvall</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>491X</b> <i>Bilateral Bronchopneumonia</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  <b>Aspiration</b>		(b)		(c)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO		DUE TO		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of the stomach</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>C</b>					
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>4</b>	Day <b>17</b>	Year <b>1955</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Emery Grove</b>	(County) <b>Gaithersburg</b> (State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>4/17/55</b> , to <b>4/23/55</b> , that I last saw the deceased alive on <b>4/23/55</b> , and that death occurred at <b>Emery Grove</b> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Emery Grove, Md.</b> DATE SIGNED <b>4/24/55</b>							
ACTUAL SIGNATURE <b>J.W. Bird</b> M.D.							
PHYSICIAN'S NAME (Type) <b>F. W. Bird, M. D.</b> Gaithersburg, Maryland							
22a. BURIAL, CREMATION, BENOVIA [Specify] <b>Emery Grove</b>	22b. DATE THEREOF <b>4/26/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Emery Grove</b>		22d. LOCATION (City, town, or county) <b>Emery Grove, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Swanson</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>	

BUREAU V. A.

APR 10 1939

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item # M91mu228 5-15-58 et

4768

## CERTIFICATE OF DEATH

Reg. Dist. No.

04737

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE	
Montgomery Maryland		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Bethesda		c. LENGTH OF STAY IN lb Suburban	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 3702 Garfield St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MARY	Middle Colette
4. DATE OF DEATH Month 4		Year 9	Day 1958
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 6 1878	
9. AGE (In years last birthday) 79 8/10 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) St. Louis	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Fante		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Thomas De Debuagio	
17. INFORMANT Address 3702 Garfield Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Hepatic Failure Carcinoma of Liver + Cholangitis		19. INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 245 p.m. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31</u> , 1958 to <u>April 9</u> , 1958, that I last saw the deceased alive on <u>April 9</u> , 1958, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE John C. Murphy PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) M.D. 1801 Eye St NW Washington 16 D.C. DATE SIGNED 4/9/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF APR. 17 1958	
22c. NAME OF CEMETERY OR CREMATORIAL N.Y.		22d. LOCATION (City, town, or county) Jeanette PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Tattnall Funeral Home		ADDRESS 3603-148 N.Y. DATE APR 11 1958 REG'D BY REGISTRAR Tattnall Funeral Home	
24b. REGISTRAR'S SIGNATURE Dated 4/11/58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X, S

APR 11 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04739

4700

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i> Maryland DC</i> b. COUNTY <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs. Bell's Nursing Home.</i>		d. STREET ADDRESS <i>Roosevelt Hotel</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Eugene</i>	Middle <i>Judd</i>	Last <i>Evans</i>	4. DATE OF DEATH <i>April 15</i>	Month Day Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 6/1858</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horseman</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>	
13. FATHER'S NAME <i>John Gough Evans</i>		14. MOTHER'S MAIDEN NAME <i>Susannah Clement</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>C. Todd Evans, (son) 3109 Hawthorn Ave. N.W. DC.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, Generalized</i>				INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i> </i>					
(c) DUE TO <i> </i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
While at work <input type="checkbox"/> At work <input type="checkbox"/>					
21. I certify that I attended the deceased from <i>July 15, 1956</i> , to <i>April 12, 1958</i> , that I last saw the deceased alive on <i>April 12, 1958</i> , and that death occurred at <i>8:25 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>James M. Whitlock</i> M.D. <i>7701 Carrollton 4-1510</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/18/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Glenwood Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Washington, D. C.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington, D. C.</i>		ADDRESS <i>Takoma Park, Md.</i>		24a. REC'D BY REGISTRAR <i>PR 17 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Whitlock</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician and completely filled in by the funeral director.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1968

NEGATIVE

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04740

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>6109 Clearbrook Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Steven</b>	Middle <b>Gressel</b>	Last <b>FENING</b>	4. DATE OF DEATH <b>April 16 1958</b>	Month Day Year						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>12 January 1958</b>	9. AGE (in years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS Days <b>4</b>	Hours <b>12</b>	Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>					
13. FATHER'S NAME <b>Raymond J. FENING</b>		14. MOTHER'S MAIDEN NAME <b>Anita GRESSELL</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Father) Raymond J. Fening (Same As #2)</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>1545</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Pneumonia, interstitial</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>					
						<i>Congenital Heart Disease</i> 3 months					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>14 April 1958</b> to <b>16 April 1958</b> that I last saw the deceased alive on <b>16 April 1958</b> , and that death occurred at <b>6:08A.M.</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>J.C. Parke Jr.</i>											
PHYSICIAN'S NAME (Type) <b>J. C. PARKE JR., LT MC USN</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l Cemetery</b>		22d LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>APR 21 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alv. search</i>					

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

BUREAU V. S.

APR 21 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01741

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>M.D.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING, MD 20956</b>		d. STREET ADDRESS <b>717-SILVER SPRING AVE</b>		
3. NAME OF DECEASED (Type or print)		First <b>ALTA</b>	Middle <b>LEELA</b>	Last <b>FINNEGAM</b>	4. DATE OF DEATH <b>4 13 1958</b>	Month <b>4</b>	Day <b>13</b>	Year <b>1958</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 22-1895</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>CHARLES HERMAN BOSS</b>		14. MOTHER'S MAIDEN NAME <b>Frances Emmaline Draper</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HUGH L. FINNEGAM</b>		Address <b>717-SILVER SPRING AVE SILVER SPRING, MD</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>59a</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Chronic glaucoma</b>		DUE TO <b>b) Chronic nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-6 mo</b>						
DUE TO <b>c)</b>				?						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchitis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injury from fall</b>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9006 COLESVILLE RD, SILVER SPRING, MD</b>		20f. (City or town) <b>SILVER SPRING, MD</b>		(County) <b>Montgomery Co.</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>JUNE</b> , 19 <b>58</b> , to <b>13 APR 1958</b> , that I last saw the deceased alive on <b>10 APR 1958</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9006 COLESVILLE RD, SILVER SPRING, MD</b>										
ACTUAL SIGNATURE <b>William D. Auld</b>		DATE SIGNED <b>1958</b>								
PHYSICIAN'S NAME (Type) <b>William D. AULD</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/16/58</b>								
22b. DATE THEREOF <b>4/16/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State) <b>DC</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Staffell - 475-4718 Wash DC</b>		ADDRESS <b>475-4718 Wash DC</b>		24a. REC'D BY REGISTRAR <b>Apr 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 13 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4771 CERTIFICATE OF DEATH

04742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
<i>Montgomery</i>				a. STATE	Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	Fairfax		
Kensington, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Carroll Hall Sanitorium		Alexandria			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>JANE</i>	Middle <i>SCOTT</i>	Last <i>FISHER</i>	4. DATE OF DEATH <i>APR 16 1958</i>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 2, 1876	'82 yrs.	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Housewife					Penn.		
12. CITIZEN OF WHAT COUNTRY?			<i>U.S.A.</i>				
13. FATHER'S NAME <i>Quincy A. Scott</i>			14. MOTHER'S MAIDEN NAME <i>Jane W. Watt</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Lawrence Kiefer, 26 South Down Rd.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i>							
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>GENERALIZED ARTERIOSCLEROSIS</i>							
DUE TO (c) <i>ESSENTIAL HYPERTENSION</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>SENILITY</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>APRIL 15, 1958</i> to <i>APRIL 20, 1958</i> , that I last saw the deceased alive on <i>APRIL 20, 1958</i> , and that death occurred at <i>8:35 PM</i> , from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <i>2206 NORTHLAND DR.</i>				
ACTUAL SIGNATURE <i>Henry J. Landine</i>			DATE SIGNED <i>4/20/58</i>				
PHYSICIAN'S NAME (Type)			22c. NAME OF CEMETERY OR CREMATORIUM <i>Lee Funeral Home</i>				
22d. LOCATION (City, town, or county) <i>Washington, D. C.</i>			(State)				
22e. DATE THEREOF <i>April 22-58</i>			22f. REC'D BY REGISTRAR DATE <i>APR 23 '58</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Demaine Jr.</i>			24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>				
ADDRESS							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU V. S.

APR 23 1950

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04743

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4772		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)		a. STATE Md		b. COUNTY Montg							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Silver Spring		10 yrs		d. STREET ADDRESS		806 Silver Spring Blvd E									
3. NAME OF DECEASED (Type or print)		First	Middle	Lost		4. DATE OF DEATH	Month	Day	Year								
3. NAME OF DECEASED (Type or print)		Olen James Fitzhugh				Apr	7		1958								
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DATE OF BIRTH		9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS									
5. SEX		male white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-19-1914		43 yrs	Months	Days	Hours	Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Salesman		haberdasher		Missouri		U.S.A.											
13. FATHER'S NAME		EARL FITZHUGH		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no				LILY BELLE (unknown)		yes						Mrs. Fern L. Fitzhugh, 3707 Woodley Rd., N.W.		Washington, D.C.		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary Edema		for hours						DUE TO		several days -			
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)  acute bronchitis tracheobronchitis								DUE TO					
				(c)													
20c. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED <u>Apr 8-1958</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>																	
22b. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/58		22c. NAME OF CEMETERY OR CREMATORIUM NATIONAL MEM. PARK CEMETERY		22d. LOCATION (City, town, or county) FALLS CHURCH, VIRGINIA		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner S. Pumphrey,</u>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE APR 11 '58		24b. REGISTRAR'S SIGNATURE <u>Albert E. Schuch</u>											
VS. AT 5ME SM 2:57																	

BUREAU X

APR 11 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04744

## 4773 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Gaithersburg		a. STATE Maryland		b. COUNTY Montg			
c. LENGTH OF STAY IN 1b		30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		14 maryland Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First George	Middle Clyde	Last Fletcher	4. DATE OF DEATH	Month April	Day 27	Year 1958	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec 13-1894	63 yrs.	Months 4	Days 14	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Pipe Fitter				Bedford Co. Pa.		U S A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Lyman C. Fletcher				Sarah Fletcher					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Mrs Anna F. Fletcher.		Gaithersburg, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RENAL FAILURE WITH UREMIA				2 MOS.			
180X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		CARCINOMA OF THE RIGHT KIDNEY				6 MOS			
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 39		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from		MAR. 7, 1958, to APR. 27, 1958		that I last saw the deceased alive on		APR. 26, 1958		and that death occurred at 6:00 A.M. from the causes and on the date stated above.	
ACTUAL MATERIAL		John H. Tuohy				ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)		John H. Tuohy		M.D.		7720 WISCONSIN AVE, BETHESDA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-29-58		22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak.		22d. LOCATION (City, town, or county) Gaithersburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest L. Garrison, Gaithersburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR APR 29 '58		24b. REGISTRAR'S SIGNATURE W. E. Deacon			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in one copy within 72 hours after death.

BUREAU V. S.  
RECEIVED  
APR 26 1952

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

104745

## 4774 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 100 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 725 DARTMOUTH AVE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 156 FLEETWOOD TER.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL VASILEOS FRANK		4. DATE OF DEATH APRIL 14	Month Day Year
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 92 11-30-188X
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT (Owner)		9. AGE (In years, last birthday) 65 yrs. IF UNDER 1 YEAR Months Days Hours Min	
10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME VASILEOS FRANK		14. MOTHER'S MAIDEN NAME unknown ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-01-4890 17. INFORMANT WM. S. FRANK (SON) Address 103 LOCKLIDGE DR. SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE, DUE TO ANGINA SECTORIS (SINCE 1945) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF LARYNX; BLADDER CARCINOMA; ANEMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ————— 19 p.m. —————		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 8, 1958, to APRIL 14, 1958, that I last saw the deceased alive on APRIL 13, 1958, and that death occurred at 2:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John G. Nason M.D. <i>John G. Nason</i> PHYSICIAN'S NAME (Type) JOHN P. NASON Washington Univ. Hosp. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/16/58	
22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner S. Humphrey,		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE APR 16 '58		Alfred	

BUREAU X-5

APR 16 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114746

## 4775 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>D. of C.</b>		b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Washington, D.C.</b>		d. STREET ADDRESS <b>5420 Connecticut Avenue, N.W.</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Mattie Strain</b>		First <b>Mattie</b>	Middle <b>Strain</b>	Last <b>Frye</b>	4. DATE OF DEATH <b>April 17 1958</b>	Month <b>April</b>	Day <b>17</b>	Year <b>1958</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 14, 1893</b>	9. AGE (In years lost birthday) <b>64 yrs.</b>	10. UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. MIN.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Johnson City, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Thomas Strain</b> <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Taylor</b> <b>Unknown</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>[If yes, give war or dates of service]</b>		17. INFORMANT (Sister-in-law) <b>Mrs. F.E. Van Haften</b>		Address <b>Atlanta, Georgia</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer metastatic</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Adolescent carcinoma of liver</b> DUE TO (c) <b>2 1/2 years</b>									INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Arlington</b>		(County) <b>Virginia</b>	(State) <b>Virginia</b>			
21. I certify that I attended the deceased from <b>Sept 16, 1952</b> to <b>April 17, 1958</b> , that I last saw the deceased alive on <b>Sept 16, 1952</b> , and that death occurred at <b>12:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ADDRESS</b>									DATE SIGNED <b>4/21/58</b>			
ACTUAL SIGNATURE <b>Survey Causins</b> M.D. # <b>347-32000-141-121</b>												
PHYSICIAN'S NAME (Type) <b>Survey Causins</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							22b. DATE THEREOF <b>4/21/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat'l</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>	(State) <b>Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The J. W. Nichols</b>		ADDRESS <b>2901-14th Street N.W.</b>							24a. REC'D BY REGISTRAR <b>S.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Debra Smith</b>	DATE <b>APR 18 '58</b>	

BUREAU V. S

400 44 400

PEACEABLE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4701

## CERTIFICATE OF DEATH

Reg. Dist. No.

04747

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park D.O.A.</i>		c. LENGTH OF STAY IN 1b <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>914 Viers Hill Rd.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Emma</i>		First	Middle	Last.	4. DATE OF DEATH <i>4 - 14 1958</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-89</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR / IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>Frank Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Weeks</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Hospital Records</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary Occlusion Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>46</i> , to <i>April 14</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 11</i> , 19 <i>58</i> , and that death occurred at <i>1:45 AM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Robert A. Hare</i> ADDRESS (Street, city or town, state) <i>2600 Carroll Ave. T.P. Md.</i> DATE SIGNED <i>4/14/58</i>								
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>4/16/58</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Mem. Park</i> 22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> (State) <i>Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i> 24a. REC'D BY REGISTRAR <i>DATE: 5 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Deb. A. Hare</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

BURKE V. S.

APR 15 1953

LAW LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04748

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rapine Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITOL HEIGHTS</b>		
3. NAME OF DECEASED (Type or print) <b>JOSEPH M.</b>		First <b>J</b>	Middle <b>M</b>	
4. DATE OF DEATH <b>APRIL 29 1958</b>	Month <b>APRIL</b>	Day <b>29</b>	Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 Dec 1893</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	
13. FATHER'S NAME <b>John J.</b>	14. MOTHER'S MAIDEN NAME <b>Anna Flavin</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			17. INFORMANT <b>John A. Geier</b>	Address <b>911-61st pl Capital Heights, Md</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? <b>NO</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>25 Apr.</b> , 1958, to <b>29 Apr.</b> , 1958, that I last saw the deceased alive on <b>29 April</b> , 1958, and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. G. Russell, Jr.</b> M.D. ADDRESS (Street, city or town, state) <b>9902 A Counselman-Rod</b> DATE SIGNED <b>4-29-58</b>				
22a. BURIAL, Cremation, BEMOVAL (Specify) <b>5-2-58</b>		22b. DATE THEREOF <b>5-2-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cem.</b>	22d. LOCATION (City, town, or county) <b>Wash. D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>800-4th st N.E.</b>	24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Allen Smith</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04749

4702

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park Md.</i>		c. LENGTH OF STAY IN 16 <i>27 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>6110 New Hampshire Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. &amp; Hospital</i>				d. STREET ADDRESS <i>6110 New Hampshire Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Louis</i>	Middle <i>Isidore</i>	Last <i>Gelles</i>	4. DATE OF DEATH <i>4/24</i>	Month <i>4</i>	Day <i>24</i>	Year <i>1958</i>
S SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/1/94</i>	9. AGE (In years last birthday) <i>63 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Interior Decorator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Morris Gelles</i>		14. MOTHER'S MARRIED NAME <i>Rosa Marder</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>577-10-8577</i>		17. INFORMANT <i>Patients Hosp. Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Coronary occlusion.		INTERVAL BETWEEN ONSET AND DEATH <i>31 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>260X</i>		(b) Acute myocardial infarction		31 hrs.			
(c) Coronary arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i></i>	(County) <i></i>
21. I certify that I attended the deceased from <i>14 Apr</i> , 1958, to <i>24 Apr</i> , 1958, that I last saw the deceased alive on <i>24 Apr</i> , 1958, and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>1011 University Blvd E. Silver Spring MD</i>						DATE SIGNED <i>24 Apr 1958</i>	
ACTUAL SIGNATURE <i>Thomas P. Fogarty M.D.</i>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/25/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>King David Mem. Garden</i>		22d. LOCATION (City, town, or county) <i>Falls Church</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Kangashy</i>		ADDRESS <i>3501-14 St NW</i>		24a. RECEIVED BY REGISTRAR <i>APR 28 1958</i>		24b. REGISTRAR'S SIGNATURE <i>W. Smith</i>	

**TO HOSPITAL**: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X-B

APR 10 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04750

## 4777 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>21 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>1200 Frederick Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Lillian</b>		First	Middle	Last	4. DATE OF DEATH <b>George April 25 1958</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-05</b>	9. AGE (in years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12 CITIZEN OF WHAT COUNTRY? <b>United States</b>		
13. FATHER'S NAME <b>Willis Isrea</b>		14. MOTHER'S MAIDEN NAME <b>Alice Howard</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT (husband) <b>Frank George</b>		Address <b>200 Frederick Ave. Rockville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic coma</b>		DUE TO				<b>1 day</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>157X</b>		(b) <b>Biliary obstruction</b>				<b>1 month</b>		
DUE TO		(c) <b>Carcinoma, Head of pancreas</b>				<b>unknown</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>none</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville</b>		(County) <b>Montgomery</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>March 25 1958</b> to <b>April 25 1958</b> that I last saw the deceased alive on <b>April 25 1958</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Dr. W. A. Linthicum</b>		DATE SIGNED <b>April 25, 1958</b>		
ACTUAL SIGNATURE <b>W. A. Linthicum</b>								
PHYSICIAN'S NAME (Type) <b>Dr. W. A. Linthicum</b>								
22a. BURIAL, CREMATION, BURIAL & CREMATION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lincoln Park</b>		22d. LOCATION (City, town, or county) <b>Rockville, Md.</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snodderly</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

SAU V. S

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04751

Reg. Dist. No.

4778

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>94 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>South Charleston</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>1609 King Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Flora</b>	Middle <b>Lee</b>	Last <b>Gum</b>	4. DATE OF DEATH <b>April 14, 1958</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 17, 1923</b>	9. AGE (In years last birthday) <b>34 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Orian Post</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Marts</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>235-60-1107</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2043</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO DUE TO (c)		ACUTE MYELOCYTIC LEUKEMIA		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>? HEPATITIS</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Charleston</b>	(County) <b>W. Va.</b> (State)
21. I certify that I attended the deceased from <b>January 10, 1958</b> , to <b>April 14, 1958</b> , that I last saw the deceased alive on <b>April 14, 1958</b> , and that death occurred at <b>6:35 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard K. Shaw</b> M.D. ADDRESS (Street, city or town, state) <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>						DATE SIGNED <b>4/15/58</b>	
PHYSICIAN'S NAME (Type) <b>Richard K. Shaw, M. D.</b>		22a. BURIAL CREMATON REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Good Hope</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Neal Funeral Home</b>		ADDRESS <b>4812 Ga Ave NW</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL may be referred to by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 21 1983

PECHVET

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4779 CERTIFICATE OF DEATH

Reg. Dist. No. 114752

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Norbeck</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>10207 Haywood Drive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Philomena Rest Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Esther</i>		First <i>V.</i>	Middle <i></i>	Lost <i>4/21/11</i>	4. DATE OF DEATH <i>April 20</i>	Month <i>April</i>	Day <i>20</i>	Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Febr 19-1878</i>		9. AGE (in years lost birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgetown, D. C.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>George Thomas Bying</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Weston</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>Silver Spring</i>			
				<i>Dorothy L. Hall 10207 Haywood Drive</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Heart Failure</i>									
450.0 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Arteriosclerosis</i>									
DUE TO (c) <i>Old Age</i>									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month <i>19</i>	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>(County)</i>	(State)		
21. I certify that I attended the deceased from <i>Sept 11, 1956</i> , to <i>April 29 1958</i> , that I last saw the deceased alive on <i>April 18 1958</i> , and that death occurred at <i>3 AM</i> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE <i>Edward J. Richards</i> M.D. 10110 George Ave. DATE SIGNED <i>4-20-58</i>									
PHYSICIAN'S NAME (Type)		Edward J. Richards							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>4/22/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Glenwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D. C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company Washington, D.C.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>APR 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Owen Cook</i>			
VS A15 (4) 15M 9/55									

BUREAU Y. S.

REGIMENT

APR 22 1944

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4780

## CERTIFICATE OF DEATH

114753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>Suburban Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Chevy Chase</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>4801 Chevy Chase Blvd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Edna</i>	Middle <i>Emma</i>	Last <i>HAMMER</i>	4. DATE OF DEATH <i>April</i>	Month <i>April</i>	Day <i>6</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 3, 1885</i>	9. AGE (in years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>10</i>	11. IF UNDER 24 HRS Days <i>3</i>	12. Hours Min. <i>00 00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Noce</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>578-70-2423B</i>		11. BIRTHPLACE (State or foreign country) <i>Chicago</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Edward Hauser</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta Raw</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Noce</i>		17. INFORMANT <i>Pearl Hauser 5411 Nebraska Av. N.W.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		36 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Hypertension</i>		7 MONTH					
DUE TO (b) <i>Heart Block</i>		7 "					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar 11</i> , 1958 to <i>April 6, 1958</i> that I last saw the deceased alive on <i>April 6, 1958</i> , and that death occurred at <i>10:50 AM</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>Bradley D Hodgkins M.D. 4413 Bradley Lane Chevy Chase, MD, 1958</i>		DATE SIGNED					
ACTUAL SIGNATURE <i>Bradley D Hodgkins M.D.</i>							
PHYSICIAN'S NAME (Type) <i>BRADLEY D HODGKINS</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/9/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey Bethesda, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>APR 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. Seach</i>	

BUREAU Y. S.

APR 9 1958

PEGEIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

114754

1. PLACE OF DEATH a. COUNTY		4703		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery MARYLAND				a. STATE Maryland	b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park		6 years		17 Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
8019 St. George Creek Parkway		18019 St. George Creek Parkway		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Christina				Hansen	4 14 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yr.
F		Caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 13, 1881	76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Denmark	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jens Marcus Jensen		Anna Christensen		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT	
No		063-18-2984		Husband Name: Andrew, 8019 St. George Creek Parkway, Takoma Park	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		SUPPURATIVE PNEUMONIA			
DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		CHRONIC SUPPURATIVE PYELONEPHRITIS 1 year			
(b)		URETERAL STENOSIS ?			
(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Carcinoma gall bladder					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15, 1958</u> , to <u>April 14, 1958</u> , that I last saw the deceased alive on <u>April 13, 1958</u> , and that death occurred at <u>125 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL TIME		<u>6:00 a.m.</u> M.D. <u>918 University Blvd. E,</u> DATE SIGNED <u>4/14/58</u>			
PHYSICIAN'S NAME (Type)		<u>Eino Magi</u> <u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
burial		April 16, 1958		George Washington Cemetery	
22d. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		22e. LOCATION (City, town, or county) (State)	
<u>J. Arthur Walters, 234 Carroll St. N.W. Wash. D.C.</u>				22f. REC'D BY REGISTRAR DAPR 17 '58	
				22g. REGISTRAR'S SIGNATURE <u>Debra Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be received by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1959

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04755

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admis. on) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 10 Days		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
3. NAME OF DECEASED (Type or print) Richard Lee HARTMAN		d. STREET ADDRESS 2918 Hickory Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4 July 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Harold Fredrick HARTMAN		14. MOTHER'S MAIDEN NAME Gladys Mildred Eling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Father) Harold F. HARTMAN (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 <i>Astrocytoma, III ventricle</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 April 1958 to 17 April 1958 that I last saw the deceased alive on 16 April 1958, and that death occurred at 12:18A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <i>John W. Troy</i>		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) John W. Troy, LCDR, MC, USN		DATE SIGNED 4-17-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arnold J. Purcell</i>		ADDRESS Cunningham, Cameron & Alfred Sts. Alex. Va.	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

BUREAU V. 2

1000

DECEMBER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4782 CERTIFICATE OF DEATH

Reg. Dist. No. 04756

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LE DEAU NURSING HOME		e. STREET ADDRESS 1545 N. FALKLAND LANE	
3. NAME OF DECEASED First NORA Middle VERONICA		4. DATE OF DEATH APRIL 29 1958	
5. SEX FEMALE		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/13/92	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael Mc Donough		14. MOTHER'S MAIDEN NAME Nora Corcoran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 159-86-2657 FRANK HARWOOD	
17. INFORMANT		Address AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mos.	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CARCINOMA OVARY WITH METASTASIS TO PERITONEUM AND LEFT PLEURA	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO	
		DUE TO	
		(c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1954, to April 29, 1958, that I last saw the deceased alive on April 29, 1958, and that death occurred at 11:55 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 2727 GEORGIA AVE. DATE SIGNED 4/29/58	
ACTUAL SIGNATURE JAMES A. ROBERTS		PHYSICIAN'S NAME (Type) JAMES A. ROBERTS SILVER SPRING, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/3/58	
22c. NAME OF CEMETERY OR CREMATORIUM PRINGLE HILL CEMETERY		22d. LOCATION (City, town, or county) KINGSTON, PA. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-3 may be relied upon by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04757

## 4783 CERTIFICATE OF DEATH

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>5 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>1831 2nd St., N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Green</b>	Middle (mm) <b>(mm)</b>	Last <b>HAWK</b>	4. DATE OF DEATH <b>April 24</b>	Month Day Year <b>Month Day Year</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Jan. 1888</b>	9. AGE (In years less b. rihday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>Green HAWK</b>			14. MOTHER'S MAIDEN NAME <b>Luminia (Last Name Unknown)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes 7-30-18 to 7-14-19</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT (Niece) Miss May Thompson (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the prostate gland</i> INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>with metastases</i> Unknown					
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-25-57</b> , 19 <b>58</b> , to <b>4-24-</b> <b>1958</b> , that I last saw the deceased alive on <b>24 April 1958</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-25-58</b>					
ACTUAL SIGNATURE <i>Robert G. Galbraith Jr. LT MC USN</i>					
PHYSICIAN'S NAME (Type) <b>Robert G. Galbraith, Jr. LT MC USN U.S. Naval Hospital, Bethesda, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-28-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Private Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Newark, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Corriveau</b>			ADDRESS <b>1432 "U" St., N.W. Washington, D.C.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 28 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>

BUREAU V. S.

APR 5 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

104758  
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>28 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>2522 "Q" St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Augustin</b>	Last <b>HEARD</b>	4. DATE OF DEATH <b>April 16 1958</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>16 January 1893</b>	9. AGE (In years lost birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Naval Officer</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
13. FATHER'S NAME <b>William D. HEARD</b>		14. MOTHER'S MAIDEN NAME <b>Mary THOMPSON</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WW-1&amp;2</b>		16. SOCIAL SECURITY NO. <b>577 48 0832</b>		17. INFORMANT <b>(Wife) Mrs. Evelyn E. Heard (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.2</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) <i>Acute Monocytic Leukemia, chronic</i> <b>3 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19 March 1958</b> to <b>16 April 1958</b> , that I last saw the deceased alive on <b>15 April 1958</b> , and that death occurred at <b>3:50A.M.</b> from the causes and on the date stated above				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
ACTUAL SIGNATURE <i>J. Dunn Jr.</i>					DATE SIGNED <b>4-16-58</b>
PHYSICIAN'S NAME (Type) <b>T. S. DUNN, JR., LT MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.		<b>4-16-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-18-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Hawley &amp; Sons</i>		ADDRESS <b>1756 Penn Ave. Washington, D.C.</b>	24a. REC'D BY REGISTRAR <b>APR 18 '58</b>	24b. REGISTRAR'S SIGNATURE <i>W. E. Schuck</i>	

BUREAU V. S.

DECODE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4785 CERTIFICATE OF DEATH

04759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>WASH</b> b. COUNTY <b>D.C.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>POTOMAC</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH D.C. 71X</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROBINE NURSING HOME</b>	d. STREET ADDRESS <b>310 - Kentucky</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>	First	Middle	Last			
4. DATE OF DEATH <b>APRIL 9 1958</b>	Month	Day	Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>IC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/1909</b>	9. AGE (In years last birthday) <b>47</b> yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS <input type="checkbox"/> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMICAL Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>YARD KIAR NC. CAR</b>		11. BIRTHPLACE (State or foreign country) <b>NC. CAR</b>		
13. FATHER'S NAME <b>Robert Heath</b>		14. MOTHER'S MAIDEN NAME <b>DORO CURTIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>310 Kentucky</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>No</b>	16. SOCIAL SECURITY NO	17. INFORMANT <b>MINNIE Heath</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GER-GEN/ ATROPHY</b> 960X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>TOTAL PARALYSIS (DECEREBRATE SYNDROME)</b> 2 YEARS DUE TO (c) <b>SKULL FRACTURE + SUBDURAL HEMATOMA</b>				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>HEAD INJURY FROM BEING KNOCKED OFF TRUCK</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>FEB 19 1958</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>WAR DEPT BLDG</b>	20f. (City or town) <b>WASH.</b>	(County) <b>D.C.</b>	(State)
21. I certify that I attended the deceased from <b>MARCH 29, 1958</b> to <b>APRIL 9, 1958</b> , that I last saw the deceased alive on <b>APRIL 8, 1958</b> , and that death occurred at <b>9<sup>00</sup> A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4830 - V ST. N.W.</b> DATE SIGNED						
ACTUAL SIGNATURE <b>EDWARD W. NICKLAS</b>	M.D.					
PHYSICIAN'S NAME (Type) <b>EDWARD W. NICKLAS</b>		WASH D.C.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/12/58</b>	22b. DATE THEREOF <b>4/12/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>LINCOLN MEMORIAL CEMETERY</b>		22d. LOCATION (City, town, or county) <b>WASHINGTON D.C.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.N. HORTON COMPANY</b>		ADDRESS <b>1322- YOU STREET, N.W.</b>		24a. REC'D BY REGISTRAR <b>APR 14 1958</b>	24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reported to Immigration  
Medical Examiner  
and approved

BUREAU V.

PR 14 1963

WILSON

~~FD-1~~  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04760

Reg. Dist. No.

4786

1. PLACE OF DEATH  
a. COUNTY

Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

a. STATE Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

✓ Chevy Chase

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

4611 Harrison Street

e. IS RESIDENCE  
ON A FARM  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

EDWIN CHARLES HENN

First Middle Last

Month Day Year

April 15, 1958

19

4. SEX

6 COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. UNDER 1 YEAR

64 yrs

IF UNDER 24 HRS

Months Days Hours Min

Male

White

WIDOWED

DIVORCED

4/25/93

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Albert W. Henn

14. MOTHER'S MAIDEN NAME

Gertrude Bruce

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

None

Augusta M. Henn - Item # 2

INTERVAL BETWEEN  
ONSET AND DEATH

sudden

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Occlusion

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause first.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

200. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m. 19

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4/15/58

220. BURIAL, CREMATION,  
REMOVAL (specify)  
Cremation

22b. DATE THEREOF  
4/15/58

22c. NAME OF CEMETERY OR CREMATORIUM  
Cedar Hill

22d. LOCATION (City, town, or county)  
Suitland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey-Bethesda, Md.

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

APR 17 '58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

BUREAU V. S.

APR 17 1958

DEGELV E D

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04761

## 4787 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>20 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>9402 Saybrook Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9402 Saybrook Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Herbert</b>		First <b>(NMM)</b>	Middle <b>(NMM)</b>	Lost <b>Heppenstall</b>	4. DATE OF DEATH <b>April 23</b>	Month <b>1958</b>	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/87</b>	9. AGE (In years lost birthday) <b>70</b>	10. IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor of Plumbing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Government</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Heppenstall</b>				14. MOTHER'S MAIDEN NAME <b>Mary Eastwood</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>VNL</b>		17. INFORMANT <b>Mrs. Florence C. R. Heppenstall, 9402 Saybrook</b>		Address <b>Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b>		DUE TO <b>Cardiac Decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <b>arteriosclerosis</b>		2					
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9006 Collevalle Rd</b>		20f. (City or town) <b>Silver Spring</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>19 April 1958</b> , and that death occurred <b>2:30 A.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b>		DATE SIGNED <b>4/23/58</b>	
ACTUAL SIGNATURE <i>William D. Aud</i>		PHYSICIAN'S NAME (Type) <b>William D. Aud</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>4/26/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>RIVERVIEW Cemetery</b>		22d. LOCATION (City, town or county) <b>SEYMOUR, INDIANA</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warren G. Humphrey</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Warren G. Humphrey</b>			

BUREAU V. S.

APR 2 1970

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4788

## CERTIFICATE OF DEATH

04762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>4406 Maple Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>E.</b>	Surname <b>HIATT</b>	4. DATE OF DEATH Month <b>April</b>	Year <b>1958</b>	Day <b>24</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-11</b>	9. AGE (in years last birthday) <b>47 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Budget Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Edgar Hiatt</b>				14. MOTHER'S MAIDEN NAME <b>Rose Lucas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Melva E. Hiatt-Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO 437.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>—</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>One hour</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>—</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> 19 p. m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that I attended the deceased from <b>April 20, 1958</b> to <b>April 24, 1958</b> , that I last saw the deceased alive on <b>April 23, 1958</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LYNWOOD HEIGES, MD, FACA</b> <b>6940 Pihey Branch Road, N.W.</b> DATE SIGNED <b>April 24, 1958</b>							
ACTUAL SIGNATURE <b>Lynwood Heiges</b>		PHYSICIAN'S NAME (Type) <b>Lynwood Heiges</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		ADDRESS DATE APR 29 1958 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>Quinn</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 10 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11763

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburbas</i>		d. STREET ADDRESS <i>2400 Hermitage Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Hattie</i>	Middle <i>May</i>	Last <i>Hill</i>
4. DATE OF DEATH	Month <i>4</i>	Day <i>4</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 24, 1897</i>
9. AGE (In years lost birthday) <i>61 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>At Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
10c. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles B. Jones</i>		14. MOTHER'S MAIDEN NAME <i>S. V. Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>223-05-4326</i>	
17. INFORMANT <i>Husband</i>		18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>916.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2° &amp; 3° Burns 60% Body Surface</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>Flash Fire Kitchen of Deceased's Home</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Flash Fire Kitchen of Deceased's Home</i>	
20c. TIME OF INJURY Hour <i>3:30 p.m.</i>		Month, Day, Year <i>12-30-57</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or Town) <i>Wheaton</i>	
20g. (County) <i>Montgomery</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>4-2</i> , 19 <i>58</i> to <i>4-4</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-4</i> , 19 <i>58</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>927 Pershing Dr. Silver Spring Md.</i>	
ACTUAL SIGNATURE <i>John P. Haberlin</i>		DATE SIGNED <i>4-4-58</i>	
PHYSICIAN'S NAME (Type) <i>John P. Haberlin</i>			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/7/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn</i>	22d. LOCATION (City, town, or county) <i>Rockville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 7 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Alberlin</i>	

BUREAU X-5

JPR 7 1958

CONFIDENTIAL

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

04764

**CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. LENGTH OF STAY IN 1b <i>36 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7202 Maple Avenue</i>				d. STREET ADDRESS <i>7202 Maple Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>LENA</i>		First <i>L</i>	Middle <i>A</i>	Last <i>HILLIARD</i>	4. DATE OF DEATH <i>April 24</i>	Month <i>April</i>	Day <i>24</i>	Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2, 1871</i>	9. AGE (in years last birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pittsburgh, Penna</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>					
13. FATHER'S NAME <i>John Keypner</i>		14. MOTHER'S MAIDEN NAME <i>Johanna Leopold</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Mrs. Florence H. Butler, (Same as #2)</i>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>											
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic arteriosclerosis</i>											
DUE TO (c) <i>Arteriosclerotic heart disease</i>											
INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic arteriosclerosis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>falling down stairs</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Pittsburgh</i>		(County) <i>Penna</i>	(State) <i>Penna</i>		
21. I certify that I attended the deceased from <i>August 1, 1954</i> to <i>April 14, 1958</i> , that I last saw the deceased alive on <i>Aug 14, 1957</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>James K. Coleman, MD</i>										ADDRESS (Street, city or town, state) <i>113 Carroll Street, Pittsburgh, Pa.</i>	DATE SIGNED <i>4/15/58</i>
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <i>Burial</i>		22b. DATE THEREOF <i>April 19, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Homewood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Pittsburgh</i>		(State) <i>Penna</i>			
23. FUNERAL DIRECTIONS SIGNATURE <i>Other</i>		ADDRESS <i>254 S. Carroll St., Pittsburgh, Pa.</i>		24a. REC'D BY REGISTRAR APR 17 '58		24b. REGISTRAR'S SIGNATURE <i>John C. C. - 1</i>					
VS A15 (4) 15M 9/55											

BUREAU V. S.

APR 17 1963

DEGAGE

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04765

## 4790 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE D.C.		b. COUNTY Rockville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1314 Hemlock St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 1314 Hemlock St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Raymond	Middle James	Last Hinton	4. DATE OF DEATH April	Month 6	Day 1958	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/89	9. AGE (In years lost birthday) 68 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Dependents Claims Service (retired)		10b. KIND OF BUSINESS OR INDUSTRY Vet. Adm.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Hinton		14. MOTHER'S MAIDEN NAME Carolyn Halstab					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War I		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Amy L. Hinton, 1314 Hemlock St., N.W. Wife		Address Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Peripherial Vascular collapse		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.			
(b) DUE TO Mesenteric Thrombosis				40 hrs			
(c) DUE TO Generalized Arteriosclerosis				Yrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Bronchitis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) A fall					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) PRIT			
21. I certify that I attended the deceased from APRIL 24, 1958, to MAY 6, 1958, that I last saw the deceased alive on MAY 6, 1958, and that death occurred at 12:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Charles J. Everding M.D. 4928 S.E. Elmo Ave Bethesda Md.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Charles J. Everding							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/9/58		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Werner Pennington Silver Spring		ADDRESS Md.		24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE Albert	

TO HOSPITALS, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be relied on by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X-5

APR 9 1958

PHOTOGRAPH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04766

## 4725 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>29 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Infant</i>	Middle <i>Male</i>	Last <i>Hutchison</i>
4. DATE OF DEATH <i>April 10, 1958</i>	Month <i>April</i>	Day <i>10</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 9, 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Albert Sayre Hutchison</i>		14. MOTHER'S MAIDEN NAME <i>Jesse Marie Baldwin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stoning the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congenital Atelectasis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>29 hrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/9</i> , 1958, to <i>4/10</i> , 1958, that I last saw the deceased alive on <i>4/10</i> , 1958, and that death occurred at <i>11 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1725 Carroll</i> DATE SIGNED <i>MD. 8224- Ga Ave Silver Spring, DC</i>			
ACTUAL SIGNATURE <i>Herbert H. Diamond</i>		PHYSICIAN'S NAME (Type) <i>HERBERT H. DIAMOND M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 12, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Olivet Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters, 254 Carroll St NW DC</i>		24a. REC'D BY REGISTRAR DATE APR 14 '58	
		24b. REGISTRAR'S SIGNATURE <i>W. E. Queen</i>	

BUREAU Y. S.

24 12 1953

REVIEWED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4791

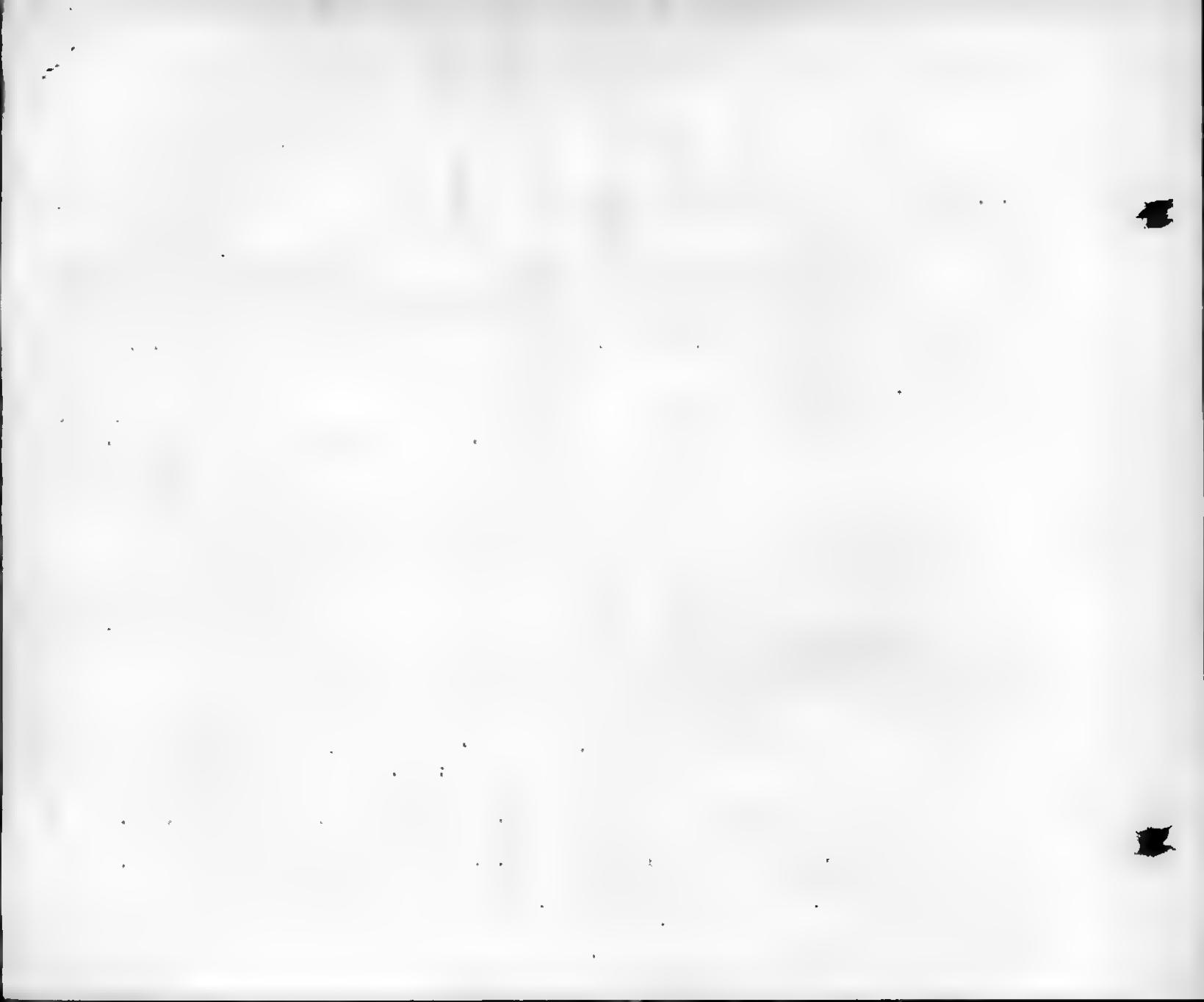
Item 14, Film G-228 5/12/58.cac

04767

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>136 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ronceverte</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e. STREET ADDRESS <b>Box 23</b>							
3. NAME OF DECEASED (Type or print)	First <b>Russell</b>	Middle <b>Paul</b>	Last <b>JOHNSON</b>	4. DATE OF DEATH <b>April 30 1958</b>	Month <b>April</b>	Day <b>30</b>	Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>26 April 1903</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS Days <b>5</b>	Hours <b>12</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>			
13. FATHER'S NAME <b>Bedford C. JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>Edna HENDERSON Hennessy.</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no. or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW-II</b>		17. INFORMANT <b>Wilson L. Johnson (Brother)</b>		Address <b>Alexandria, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			Infarction of Myocardium  Coronary Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH <b>1½ hours.</b>			
DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						Undetermined			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)  M.D. U.S. Naval Hospital, Bethesda, Md.	(County) (State)		
21. I certify that I attended the deceased from <b>15 Dec. 1957</b> to <b>30 April 1958</b> , that I last saw the deceased alive on <b>30 April 1958</b> , and that death occurred at <b>10:35A.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Orren L. Royal, M.D.</i>									
PHYSICIAN'S NAME (Type) <b>Orren L. Royal, LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-4-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Riverview Cemetery</b>			22d. LOCATION (City, town, or county) <b>Ronceverte, West Virginia</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wallace &amp; Wallace, Ronceverte, W. Va.</i>		24a. REC'D BY REGISTRAR <b>MAY 6 '58</b>			24b. REGISTRAR'S SIGNATURE <i>Albertus</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04768

4792

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <b>Montgomery</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		d. STREET ADDRESS <b>9 Neptune Green, S.W.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sharon</b>	First <b>Sharon</b>	Middle <b>Kay</b>	Last <b>JOHNSON</b>	4. DATE OF DEATH <b>April 6 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1932</b>	9. AGE (In years lost birthday) <b>26 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>Charles BAUGH</b>		14. MOTHER'S MAIDEN NAME <b>Agnes KAUSEE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>314 30 6295</b>	17. INFORMANT <b>(Husb) Herbert F. Johnson</b>	Address <b>9 Neptune Green, S.W. Washington, D.C.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Malignant teratoma, ovary, with generalized carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				
(c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 13, 1958</b> , to <b>April 6, 1958</b> , that I last saw the deceased alive on <b>April 6, 1958</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above				
ACTUAL SIGNATURE <i>C.R. Boyce</i>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-7-58</b>		
PHYSICIAN'S NAME (Type) <b>C. R. BOYCE, LT, MC, USN</b>		Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-11-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		ADDRESS <b>517 11th St, SE, Washington</b>	D.C.	24a. REC'D BY REGISTRAR <b>APR 9 '58</b>
VS A15 (4) 15M 10/57		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>		

BUREAU V. S.

APR 9 1998

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04769

Reg. Dist. No.

## 4793 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Opa Locka		d. STREET ADDRESS 3510 N. W. 170th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Julie	Middle Ann	Last Kackley	4. DATE OF DEATH May 16, 1953	Month April	Day 8	Year 58
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 16, 1953	9. AGE (In years lost birthday) 4 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julian Kackley		14. MOTHER'S MAIDEN NAME Pearle Tenny					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  754.2		Ventricular fibrillation				INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		Closure of ventricular septal defect				1 hr. 20 min.	
(c) DUE TO		Ventricular septal defect and pulmonary hypertension Congen.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1958, to April 8, 1958, that I last saw the deceased alive on April 8, 1958, and that death occurred at 1:50 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 4-8-58	
ACTUAL SIGNATURE J. Richard Crout, M.D.			The Clinical Center				
PHYSICIAN'S NAME (Type) J. Richard Crout, M.D.			National Institutes of Health				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L.		22d. LOCATION (City, town, or county) ARLINGTON, VA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Warren Tallman		ADDRESS 3603-14 <sup>th</sup> St NW		24a. REC'D BY REGISTRAR DATE APR 10 '58		24b. REGISTRAR'S SIGNATURE A. L. Seach	
						Wash. D.C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 10 1962

REGISTRY FILE

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

04770

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md.		c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) SUBURBAN HOSPITAL		e. STREET ADDRESS 2511 Holman Ave		
3. NAME OF DECEASED (Type or print) AGNES		First T.	Middle KANE	
4. DATE OF DEATH APRIL 17 1958	Month Day Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1906	
9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		
10c. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD WHIPPLE		14. MOTHER'S MAIDEN NAME ANN MOZAN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no unknown)		16. SOCIAL SECURITY NO. No		
17. INFORMANT Dominic R. KANE (Address)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416X</b> DUE TO <b>Cardiac decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <b>Rheumatic fever</b> (c)				
INTERVAL BETWEEN ONSET AND DEATH <b>3-4 years</b> <b>at 11 yrs</b> <b>of age</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <b>William D. Auld</b> M.D. ADDRESS (Street, city or town, state) <b>9006 Collegeton Rd</b> DATE SIGNED <b>4/17/58</b>				
22a. BURIAL/CREMATION/REMOVAL (Specify) <b>4/21/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <b>W.W. Talmorrell 3603 14th St. NW</b>		22d. LOCATION (City, town, or county) <b>New York</b> (State) <b>N.Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Talmorrell</b>		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

DO. 1 1959

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4795 CERTIFICATE OF DEATH

04771

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>106 Lucas Lane</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Lucas Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Richard Christian Klug</b>		First	Middle	Last	4. DATE OF DEATH <b>April 4 1958</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 5, 1878</b>	9. AGE (in years lost birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Herman Klug</b>		14. MOTHER'S MAIDEN NAME <b>Mary Vogenitz</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>389-01-8946</b>		17. INFORMANT <b>Erna Olafson (Daughter)</b>		Address <b>same as 2 d</b>		
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypernephroma, rt. Kidney</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b>								
180X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus.</b>								
DUE TO (c) <b>Arteriosclerosis</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Diabetes mellitus. 2) Arteriosclerosis</b>						
20c. TIME OF INJURY Hour o. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>M.D. 1830 K St., NW Wash. DC</b>		(County) <b>4/4/58</b> (State)
21. I certify that I attended the deceased from <b>3/7 1958</b> , to <b>4/4 1958</b> , that I last saw the deceased alive on <b>4/4/58 1958</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>M.D. 1830 K St., NW Wash. DC</b>								
DATE SIGNED <b>4/4/58</b>								
ACTUAL SIGNATURE <b>Joseph J. Wallace</b>								
PHYSICIAN'S NAME (Type) <b>Joseph J. Wallace, M.D.</b>		1830 K St., NW Washington, D.C.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Removal</b>		22b. DATE THEREOF <b>4/5/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>UNION CEMETERY</b>		22d. LOCATION (City, town, or county) <b>Milwaukee</b> (State) <b>WI</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hammie Son</b>		ADDRESS <b>1756 Pa., Ave. NW Washington, DC</b>		24a. REC'D BY REGISTRAR <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Askevold</b>		

APR 7 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04772

## 4796 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington, D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pittsburgh</i>		c. LENGTH OF STAY IN lb <i>2 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>2212 7th St. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Pearl C. Koenig</i>		First	Middle	Last	4. DATE OF DEATH Month Day Year <i>April 26, 1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1892 Dec. 28 65</i>	9. AGE (In years from birthday) yrs. <i>65</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Buffalo, N.Y.</i>	
13. FATHER'S NAME <i>John Weller</i>		14. MOTHER'S MAIDEN NAME <i>Libbe</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>William H. Koenig-2212 7th St. N.W.</i>	
Address <i>2212 7th St. N.W., Washington, D.C.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetes mellitus</i> DUE TO (c) <i>Valvular heart disease (arteriosclerosis)</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> 5 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>ulcer, leg (cold) thrombophlebitis</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>some</i> , 19 <i>57</i> , to <i>Apr. 26, 1958</i> that I last saw the deceased alive on <i>Apr. 16, 1958</i> , and that death occurred at <i>7:05 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i>					
ACTUAL SIGNATURE <i>Philip H. Verner, M.D.</i> DATE SIGNED <i>1/26/58</i>					
PHYSICIAN'S NAME (Type) <i>Philip H. Verner, M.D.</i>		22d LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL OF BODY <i>burial</i>		22b. DATE THEREOF <i>4/29/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The J. A. Hines Co.</i>		ADDRESS <i>2901 14th St. N.W.</i>		24a. RECD BY REGISTRAR DATE <i>APR 23 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Asst. Secy.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PEGEON V.  
BUREAU

APR 22 1968

100-1000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4797 CERTIFICATE OF DEATH

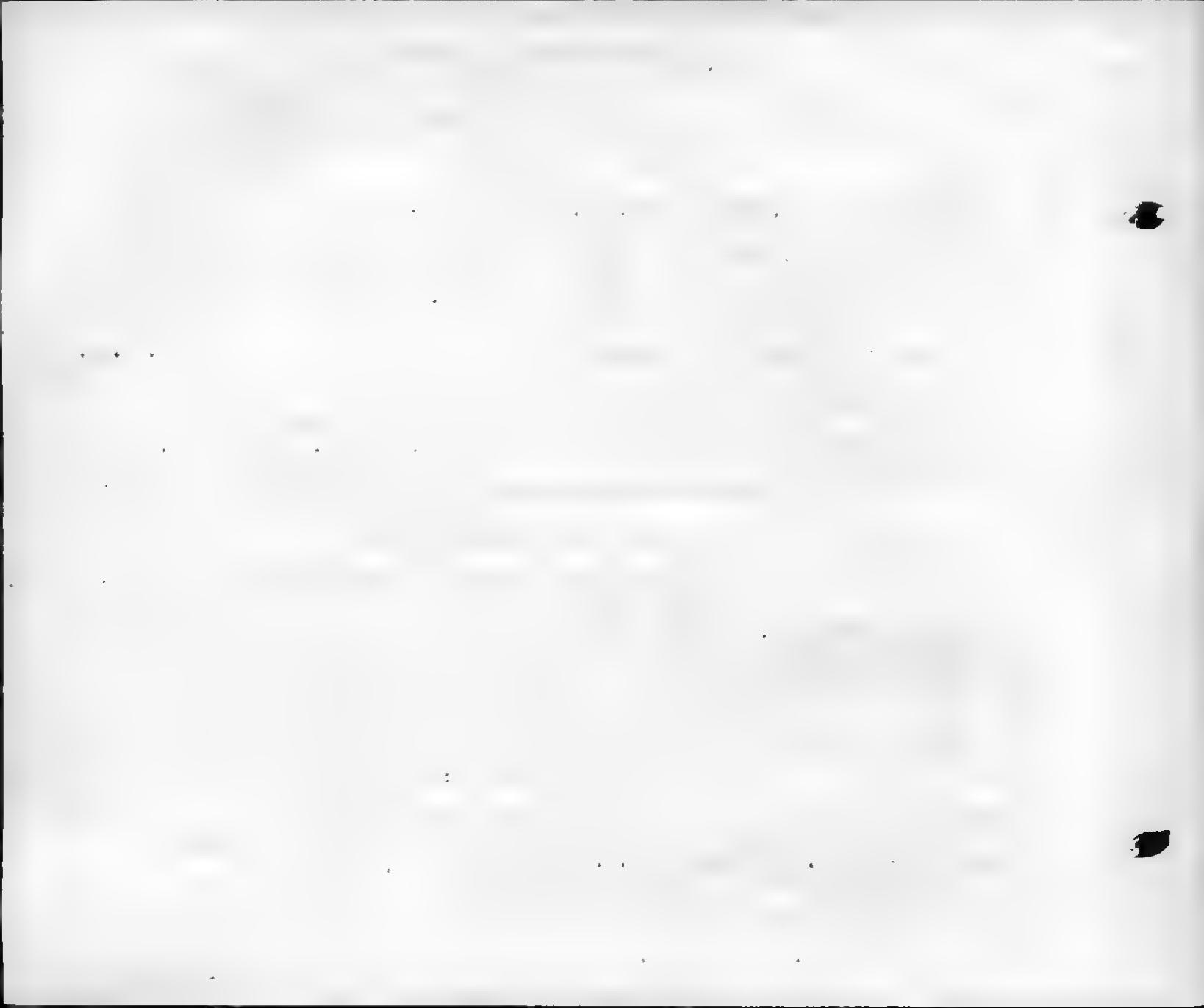
Reg. Dist. No.

04773

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>New Jersey</b>		b. COUNTY <b>Passaic</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>56 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Paterson</b>		d. STREET ADDRESS <b>354 East 42nd Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lawrence</b>	Middle <b>Francis</b>	Last <b>Kramer</b>	4. DATE OF DEATH <b>April 30 1958</b>	Month <b>April</b>	Day <b>30</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1895</b>	9. AGE (In years last birthday) <b>63</b> yr	IF UNDER 1 YEAR Months <b>63</b>	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor - Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Supply</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Phillip Kramer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Conway</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WII</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>13 Days</b>	
DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260X</b>		(b) <b>Hypertensive Cardiovascular Disease</b>				20 Years	
DUE TO <b>(c) Generalized Arteriosclerosis &amp; Arteriolar nephrosclerosis 20Yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus, Tophaceous Gout</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on ADDRESS (Street, city or town, state)		March 5, 1958, to April 30, 1958, that I last saw the deceased and that death occurred at 2:50 PM, from the causes and on the date stated above.				DATE SIGNED <b>5/1/58</b>	
ACTUAL SIGNATURE <i>J. E. Seegmiller</i>		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) <b>JARVIS E. SEEGMILLER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Calvary Cemetery</b>		22d. LOCATION (City, town, or county) <b>Patterson, New Jersey</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Inc.</b>		23. FUNERAL DIRECTOR'S ADDRESS <b>317 Pa. Ave SE DC3</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Albert Schuck</i>	

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4798 CERTIFICATE OF DEATH

04774

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS Route #3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Anna	Middle Mary	Last Krepelka	4. DATE OF DEATH April 25,	Month April	Day 25, 1958	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1900	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Days 13	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antoin Maticka		14. MOTHER'S MAIDEN NAME Mary Fijalo					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2042 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c)		DUE TO <i>Intra cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH 9 hrs.			
		DUE TO <i>Acute monocytic Leukemia</i>		3 mos.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 23, 1958, to April 25, 1958, that I last saw the deceased alive on April 25, 1958, and that death occurred at 1:10 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland				DATE SIGNED 4/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-58		22c. NAME OF CEMETERY OR CREMATORIUM Macdonaldta			
22d. LOCATION (City, town, or county) Somerset Co. Penna.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 28 '58			
				24b. REGISTRAR'S SIGNATURE Allred			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

APR 28 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4799 CERTIFICATE OF DEATH

Reg. Dist. No.

04775

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN Tb RURAL and give nearest town <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>728 McAllister Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Helen</b>	Middle <b>Virginia</b>	Last <b>Krug</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>18</b>	Year <b>1958</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 4, 1926</b>	9. AGE (In years last birthday) <b>31</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Uriah Wents</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> DUE TO <b>09 dx</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <b>? viral hepatitis</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>Choriocarcinoma with metastases to brain, lungs, and intestine</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1958</b> , to <b>April 18, 1958</b> , that I last saw the deceased alive on <b>April 18, 1958</b> , and that death occurred at <b>5:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4/18/58</b>							
ACTUAL SIGNATURE <i>Allen David Goodman</i>	M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-18-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hanover</b>		(State) <b>Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis R. G. Wetzel</i>	ADDRESS <b>Hanover Pa.</b>	24a. REC'D BY REGISTRAR <b>APR 22 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Allen David Goodman</i>			

BUREAU V. S.

APR 11 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4706 CERTIFICATE OF DEATH

04776

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rock-Aren Ave.</i>		d. STREET ADDRESS <i>15411 Good Hope Road</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Kathleen</i>	Middle <i>Elizabeth</i>	Last <i>KRUTHM</i>	
4. DATE OF DEATH <i>APRIL 15 1958.</i>	Month	Day	Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May - 9 - 1917</i>	
9. AGE (in years lost birthday) <i>40 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife Own Home</i>	11. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Martinsburg-W. Va.</i></i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jeffery W. DeLoren</i>	14. MOTHER'S MAIDEN NAME <i>Thelma Pfitzer</i>	Address <i>15411 Good Hope Rd.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>578-09-3173</i>	17. INFORMANT <i>Germann Krebs</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b)  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TERMINAL bronchopneumonia 3 days Hemiplegia Cancer of the brain unknown	INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. g. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 17, 1958</i> , to <i>April 15, 1958</i> , that I last saw the deceased alive on <i>April 14, 1958</i> , and that death occurred at <i>4:45 A.M.</i> from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>EINO MAGI</i>		ADDRESS (Street, city or town, state) <i>918 University Blvd. E., Silver Spring, Maryland</i>		
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>4/15/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 17, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>	22d. LOCATION (City, town, or county) <i>Bethesda</i>	(State) <i>MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Wallace</i>		240. REC'D BY REGISTRAR <i>APP</i>	241. REGISTRAR'S SIGNATURE <i>RL</i>	
ADDRESS <i>254 Carroll St.</i>		DATE		

C. M. YOUNG

BUREAU V. S.

17 NOV 1943

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04777

## 4800 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>86 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>	
3. NAME OF DECEASED (Type or print) <b>Macario</b>		d. STREET ADDRESS <b>1210 Broadview Blvd.</b>	
4. DATE OF DEATH <b>LA SON</b>		Month <b>April</b>	Day <b>9</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Malayan</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>9-1-98</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Philipine Islands</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Perfecto LACSON</b>		14. MOTHER'S MAIDEN NAME <b>Unknown NARCISI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WVI &amp; WVI 212 30 4713</b>	
17. INFORMANT <b>(Wife) Virginia C. Lacson, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>146 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		Carcinoma, squamous cell, nasal pharynx with cerebral metastasis INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 14, 1958</b> , to <b>April 9, 1958</b> , that I last saw the deceased alive on <b>April 9, 1958</b> , and that death occurred at <b>1:35 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>M. C. SHEA</b>		M.D. <b>U. S. Naval Hospital, NNMC</b> 4-10-58	
PHYSICIAN'S NAME (Type) <b>M. C. SHEA, LT, MC, USN</b>		Bethesda 14, Maryland	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Meadow Ridge Memorial Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Howard County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JAMES G. Kirkley</b>		ADDRESS <b>421 Crain Hwy.</b>	
		24a. REC'D BY REGISTRAR <b>Glen Burnie, Md.</b>	
		24b. REGISTRAR'S SIGNATURE <b>APR 14 1958</b>	
VS A15 (4) 15M 10/57			

BUREAU Y.

Sept 14 1958

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4801

## CERTIFICATE OF DEATH

04778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>63 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>15808 Sycamore Lane</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Joyce</b>	Middle <b>Carol</b>	Last <b>Lanczkowski</b>	4. DATE OF DEATH <b>April 21, 1958</b>	Month <b>April</b>	Day <b>21</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 21, 1934</b>	9. AGE (in years from birth) <b>23</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Victor Leisner</b>		14. MOTHER'S MAIDEN NAME <b>Florence Hoppe</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>229-36-0625</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO <b>INTRACEREBRAL HEMORRHAGE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <b>CHRONIC MYELOGENOUS LEUKEMIA</b>		3 YEARS			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>February 17 1958</b> to <b>April 21, 1958</b> , that I last saw the deceased alive on <b>April 21, 1958</b> , and that death occurred at <b>12:50 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>I. Bernard Weinstein</i> M.D. ADDRESS (Street, city or town, state) <b>I. Bernard Weinstein, M. D.</b> PHYSICIAN'S NAME (Type) <b>I. BERNARD WEINSTEIN</b> DATE SIGNED <b>4/21/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Grace Lawn Mem. Cemetery Farnhurst,</b>		22d. LOCATION (City, town, or county) <b>Del.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. Hanes Co.</b>		ADDRESS <b>2901-14th St. N.W. Wash. D.C.</b>		24a. RECEIVED BY REGISTRAR <b>APR 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. Johnson</b>	

BUREAU V. S

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04779

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in office, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial; cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4802		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Montgomery		MARYLAND		a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 DOA		b. COUNTY Montgomery		
Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		51 Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Parking lot rear Roth Theatre		131 Stonington Rd.				
f. STREET ADDRESS						
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year	
Joseph W. Langford				April 23 1958		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 56 yrs.	
Male		White		7/20/01	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Heating Engineer		E.C. Keys & Son-Fuel		Washington, D.C.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
Sidney W. Langford		Mary J. McLain		USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		
		578-36-2701		Mrs. Catherine N. Langford, 319 Stonington Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address Silver Spring, Md.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				
420.1		DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)				
		DUE TO				
		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Sudden Fell dead on parking lot.				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
ACTUAL SIGNATURE		Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 23, 1958 DATE SIGNED
EXAMINER'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/26/58		22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D. C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Lumphrey, SILVER SPRING, MD.				24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE Audie Smith

BUREAU V. S.

APP 113

REGULATIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04780

4803

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>				e. STREET ADDRESS <b>201 Elmira St., S.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>William</b>	Last <b>LARSON, II</b>	4. DATE OF DEATH <b>April</b>	Month <b>11</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-1-58</b>	9. AGE (In years lost birthday) yrs <b>10</b>	IF UNDER 1 YEAR Months <b>10</b>	IF UNDER 24 HRS Days <b>10</b>	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John William LARSON</b>		14. MOTHER'S MAIDEN NAME <b>Mary HEATH</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(Father) John W. Larson, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ague</b> DUE TO <b>6 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Cold</b> (c) <b>Influenza</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Hypertension &amp; arteriosclerosis - cerebral hemorrhage</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>April 5 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U. S. Naval Hospital, NNMC</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 5, 1958</b> to <b>April 11, 1958</b> , that I last saw the deceased alive on <b>April 11, 1958</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Kenneth W. Sell</b> M.D. U. S. Naval Hospital, NNMC 4-11-58							
PHYSICIAN'S NAME (Type) <b>Kenneth W. SELL, LT, MC, USN</b> Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-15-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington</b> <b>Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave.,</b> ADDRESS <b>Bethesda, Md.</b> 24a. REC'D BY REGISTRAR <b>DAAPR 15 '58</b> 24b. REGISTRAR'S SIGNATURE <b>R. A. Pumphrey</b>							

TO HOSPITAL OR ATTENDANT PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

83

BURLEAU V. S.

APR - 1953

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04781

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4804 Montgomery Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		Ind	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Hypatia town		2 mo		X Hypatia town			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Md Route 355		STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day
Helen Elsie Lee					April	15	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
Female		col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-3-1908	44	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cook-Restaurant				Frederick Md.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Grayson Larkins		Maria Butler		Florence-Springs - 101 S. Bentz St. Frederick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No		219-07-2318		Florence-Springs		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)		06		DUE TO	
		(c)				DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE	<i>Frank J. Brochart</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>Apr 15 1958</i>
EXAMINER'S NAME (Type)	<i>FRANK J. BROCHART</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM			22d. LOCATION (City, town, or county)	(State)	
Burial	4-18-58	FAIRVIEW			Frederick Md.		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS			24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
Charles E. Hicks III	Frederick Md.			APR 25 '58	Alib couch		

TRAU V. S.

APR 5 1959

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4707 CERTIFICATE OF DEATH

Reg. Dist. No.

04782

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 hrs +</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>804 Elm Ave</i>			
d. NAME OR HOSPITAL (If not in hospital, give street address) or INSTITUTION <i>Washington Sanitarium &amp; Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Max C.M.N. Lipai</i>		First	Middle	Last	4. DATE OF DEATH Month Year <i>4 - 5 1955</i>	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-10-85</i>	9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>			
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hospital Records</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>			
(b)						 <i>20 years</i>			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>414</i>	20f. (City or town) <i>Falls Church</i>	(County) <i>VA</i>	(State) <i>VA</i>
21. I certify that I attended the deceased from <i>4/4 1958</i> to <i>4/5 1958</i> , that I last saw the deceased alive on <i>4/5/58</i> , and that death occurred at <i>5:15 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>1414 Landerwood NW DC 20009</i>			DATE SIGNED <i>4/5/58</i>
ACTUAL SIGNATURE <i>Bill Dall</i>									
PHYSICIAN'S NAME (Type) <i>Bill Dall M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>4/7/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>NATL. Mem Park</i>		22d. LOCATION (City, town, or county) <i>Falls Church, VA</i>		(State) <i>VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Heedberg Funeral Home</i>		ADDRESS <i>4217-9th St. NW Wash. D.C.</i>		24a. REG'D BY REGISTRAR DATE <i>APR 8 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. Deane</i>			

BUREAU Y. S.

• 3 8 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04783

4805

## CERTIFICATE OF DEATH

Reg. Dist. No.

Item 7, Film G-229 5/23/58, sac.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Henrico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>348 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b>		d. STREET ADDRESS <b>1601 Kensington Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Melton</b>	Last <b>Locknane</b>	4. DATE OF DEATH <b>April 16 1958</b>	Month <b>April</b>	Day <b>16</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1908</b>	9. AGE (in years lost birthday) <b>49</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Dots Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman, Route man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food products</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James C. Locknane</b>				14. MOTHER'S MAIDEN NAME <b>Lavonia Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>223-01-4324</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>161X</b> DUE TO <i>Epidemioid carcinoma larynx</i>							
INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atelectasis, Bronchopneumonia left lung</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Injury occurred while at work</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1601 Kensington Avenue</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3, 1957</b> to <b>April 16, 1958</b> , that I last saw the deceased alive on <b>April 16, 1958</b> , and that death occurred at <b>6:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Robert B. Couch, M.D.</b>							
ACTUAL SIGNATURE <i>Robert B. Couch</i>		DATE SIGNED <b>4/16/58</b>					
PHYSICIAN'S NAME (Type) <b>Robert B. Couch, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4/16/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) <b>Richmond, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>APR 18 '58</b>	24b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 18 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04784

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jesuit High School</u>		d. STREET ADDRESS <u>1602 Henry Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lelia</u>		First <u>V.</u>	Middle <u>Loy</u>	4. DATE OF DEATH <u>April 5</u>	Month <u>1958</u>	Day <u>5</u>	Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/17</u>	9. AGE (in years (last birthday) <u>76 yrs.</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Albert P. Loy</u>		14. MOTHER'S MAIDEN NAME <u>Lelia Poole</u>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-28-4057</u>	17. INFORMANT <u>Son (Charles E. J. Loy)</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>448 X</u>		{ (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of breast, recurrent</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>427 Victoria Rd.</u>		(County) (State) <u>Baltimore Md.</u>	
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>58</u> to <u>4-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-4</u> , 19 <u>58</u> , and that death occurred at <u>4-5</u> , 19 <u>58</u> M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) <u>427 Victoria Rd.</u>		DATE SIGNED <u>4-1-58</u>			
ACTUAL SIGNATURE <u>W.B. Williams</u>		M.D. <u>William B. Williams</u>					
PHYSICIAN'S NAME (Type) <u>William B. Williams</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Williams</u>		ADDRESS <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert J. Loy</u>	

BUREAU Y.

APR 9 1959

LEGATIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 F11-227 4-11-58 et

04785

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Rest Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville,,</b>	
3. NAME OF DECEASED (Type or print) <b>Marbury</b>		f. STREET ADDRESS	
LAST <i>Marbury</i> Middle <i>Matilda</i>		4. DATE OF DEATH <i>April 3, 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 2, 1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland, Md.</b>	
13. FATHER'S NAME <b>Noah Beekwith</b>		14. MOTHER'S MAIDEN NAME <b>Susan Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Ruth E. Turner</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia Cardiac Decomp.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Gangrene Both feet Decubitus</i> DUE TO <i>Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>April 2, 1958</i> , to <i>April 2, 1958</i> , that I last saw the deceased alive on <i>April 2, 1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Webster Sewell M.D.</b> <i>Rockwell Pl., Silver Spring, Md.</i>			
ACTUAL SIGNATURE <i>Webster Sewell</i>		DATE SIGNED <i>4-5-58</i>	
PHYSICIAN'S NAME (Type) <b>WEBSTER SEWELL</b>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Jerusalem, Baptist,</b>		22d. LOCATION (City, town, or county) <b>Poolesville, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sanden</i>		24a. REC'D. BY REGISTRAR <b>APR 9 '58</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Askeach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

APR 9 1958

REGIME

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04786

FOR STATE  
HEALTH DEPT.

■■■■■ MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4808	Item 2 Film G231 7-9-58 et		Reg. Dist. No.										
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]		Bethesda	c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Alta Vista Rest home	e. STATE		MD										
3. NAME OF DECEASED (Type or print)		First: Max	Middle: Marshall	b. COUNTY											
4. SEX		Male	5. COLOR OR RACE	White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		Lost	14. DATE OF DEATH	Month	Day	Year		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE in years (not birthday)		15. CITIZEN OF WHAT COUNTRY?		16. SOCIAL SECURITY NO.		17. INFORMANT			
Caf. driver				Russia		79 yrs		U.S.A.		578-46-4528 Rest Home Records		Address			
13. FATHER'S NAME		Israel Marshall		14. MOTHER'S MAIDEN NAME		Rose Kremser									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion		420.1		DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)		DUE TO		Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		Frank J. Broschart		4-28-58		Lee'd Cemetery		Wish DK		APR 25-58					
ACTUAL SIGNATURE:		EXAMINER'S NAME (Type):		22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		DATE SIGNED			
FRANK J. Broschart		Lee Funeral Home - Wash DC		4-28-58		ADDRESS				APR 30 '58		REGISTRAR'S SIGNATURE			
VS. A15ME SM 2.57		23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE									

BUREAU V. S

1980 1980

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04787

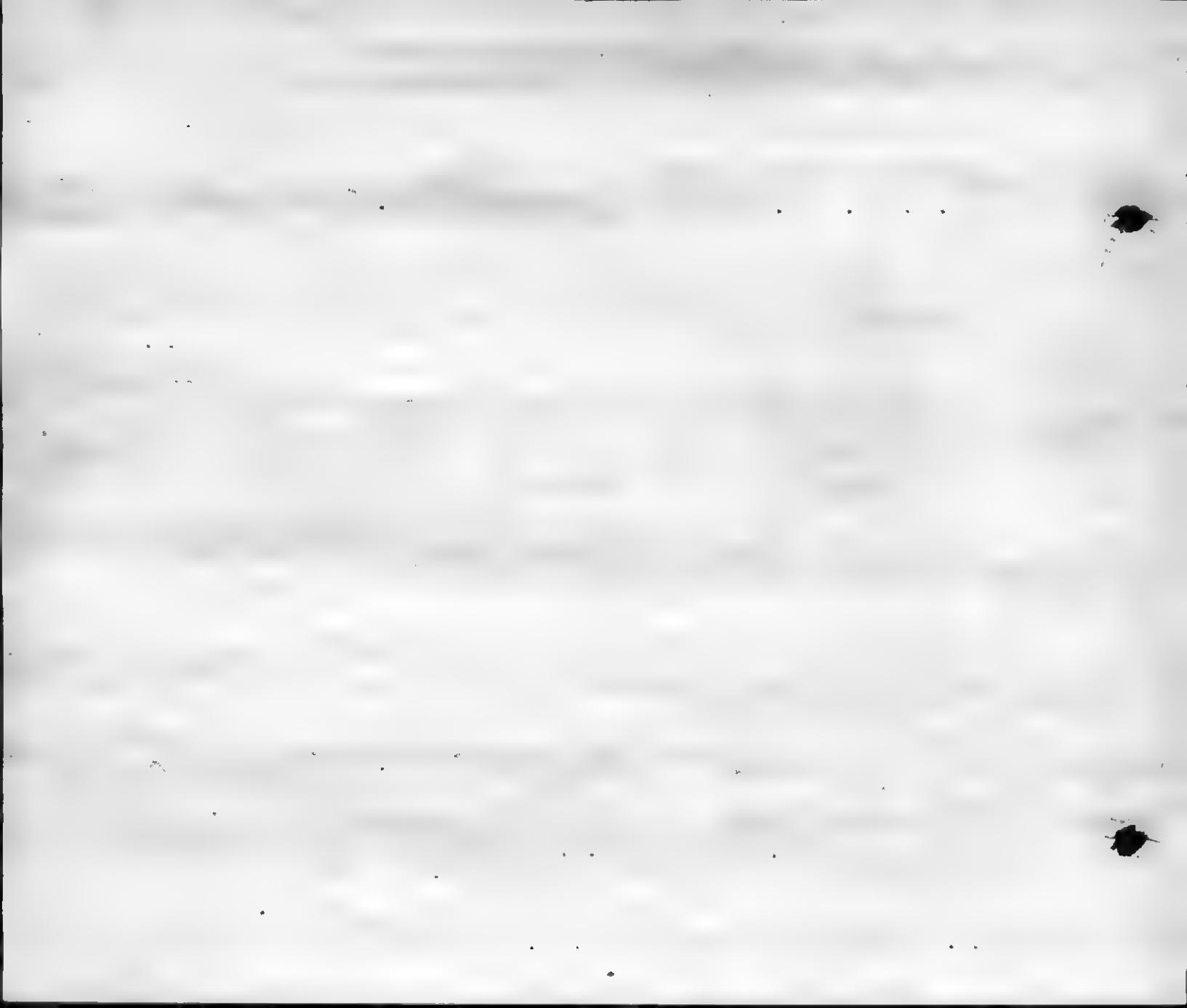
## 4809 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>		d. STREET ADDRESS <b>Trotter Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hont. Co. Gen. Hosp.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <b>Isabelle</b>	Middle <b>B.</b>	Last <b>Matthews</b>	4. DATE OF DEATH	Month <b>4</b>	Day <b>30</b>	Year <b>1958</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs. <b>79</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Barker</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>8/</b>		17. INFORMANT <b>Walter Matthews</b>		Address <b>Trotter Rd, Clarksville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Secondary anemia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 3, 1954</b> , to <b>April 30, 1958</b> , that I last saw the deceased alive on <b>April 30, 1958</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Clarksville, Md.</b>							
DATE SIGNED <b>5-1-58</b>							
MEDICAL CERTIFICATION							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>5/3/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albreach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4810 CERTIFICATE OF DEATH

Reg. Dist. No. 04788

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Chevy Chase				Chevy Chase		4307 Elm Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4307 Elm Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>W.</i>	Middle <i>Mattingley</i>	Last <i>Mattingley</i>	4. DATE OF DEATH	Month APRIL	Day 17	Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS		
female		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6/5/72	Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired fitter Woodward &洛throp				Harford County, Md.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
William Holloway		Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				J. Fredrick Mattingley		4307 Elm St. C.C. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypophesarcoma of stomach</i> DUE TO <i>200.1</i>								
Conditions, if any, which gave rise to immediate cause (a), slating the under-lying cause last. (b) <i>Enteritis Acute</i> DUE TO <i>200.1</i> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Enteritis Acute</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Augt 20, 1957</i> to <i>April 17, 1958</i> , that I last saw the deceased alive on <i>April 16, 1958</i> , and that death occurred at <i>1673 Park Rd. N.W. Wash. D.C.</i>		ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE <i>James M. Loftus, M.D.</i>		DATE SIGNED						
PHYSICIAN'S NAME (Type)		1673 Park Rd. N.W. Wash. D.C.						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Angel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS 2901 14th St. N. W. Wash. 9, D.C.		24a. REC'D BY REGISTRAR DATE APR 18 '58		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04789

## 481 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Nansemond</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>35 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Portsmouth</b>		d. STREET ADDRESS <b>Qtrs. 115A, Marine Corps Supply Fwd. Annex</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>				d. STREET ADDRESS <b>Qtrs. 115A, Marine Corps Supply Fwd. Annex</b>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Elsie Jean McDANIEL</b>		First	Middle	Los	4. DATE OF DEATH <b>April</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-22</b>	9. AGE (In years lost birthday) <b>35 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS DAYS	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beutician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beutician</b>		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Ralph KITNER</b>		14. MOTHER'S MAIDEN NAME <b>Annie FERTENBAUGH</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>184 12 4279</b>		17. INFORMANT <b>(Husband) Charles B. McDaniel, Jr. Same as #2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, lung, with metastasis</b>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>				
21. I certify that I attended the deceased from <b>March 5, 1958</b> , to <b>April 8, 1958</b> , that I last saw the deceased alive on <b>April 7, 1958</b> , and that death occurred at <b>6:40A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>F. H. O'Connell</b> M.D. U. S. Naval Hospital, NNMC 4-9-58								
PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LT, MC, USN</b>		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-11-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		ADDRESS Bethesda, Md. <b>R. A. Pumphrey Funeral Home 7557 Wisc. Ave.</b>		24a. REC'D REGISTRAR'S SIGNATURE <b>4-11-58</b>		24b. REGISTRAR'S SIGNATURE <b>John Louch</b>		
				DATE				

BUREAU V. S.

APR 11 1963

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4812 CERTIFICATE OF DEATH

04790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Mongtomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Bethesda</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5112 Wessling Lane</b>				d. STREET ADDRESS <b>5112 Wessling Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EDWARD P. McDEVITT</b>		First	Middle	Last	4. DATE OF DEATH <b>April 20, 1958</b>	Month	Day	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1879</b>	9. AGE (in years last birthday) <b>79 yrs</b>	10. IF UNDER 1 YEAR <b>1</b>	11. IF UNDER 24 HRS <b>8</b>	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proof reader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13. FATHER'S NAME <b>Martin McDevitt</b>				14. MOTHER'S MAIDEN NAME <b>Florence Sewall</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Grace M. Andrews, Saul Rd. Beth. Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b>		DUE TO <b>Bronchopneumonia, terminal</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>Carcinoma of pancreas</b>				<b>1 year</b>		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1) Diabetes Mellitus 257X 2) Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) (State)				
21. I certify that I attended the deceased from <b>March 10, 1948</b> , to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 20, 1958</b> , and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>M.D. 5009 Del Ray Ave., Bethesda</b>		
ACTUAL SIGNATURE <b>Robert G. Angle</b>						DATE SIGNED <b>4/20/58</b>		
PHYSICIAN'S NAME (Type) <b>Robert G. Angle</b>		22b. DATE THEREOF <b>4/22/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		ADDRESS		24e. REC'D BY REGISTRAR DATE		24f. REGISTRAR'S SIGNATURE <b>Alt. Leach</b>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU V. S.  
SOCIETY  
1929

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04791

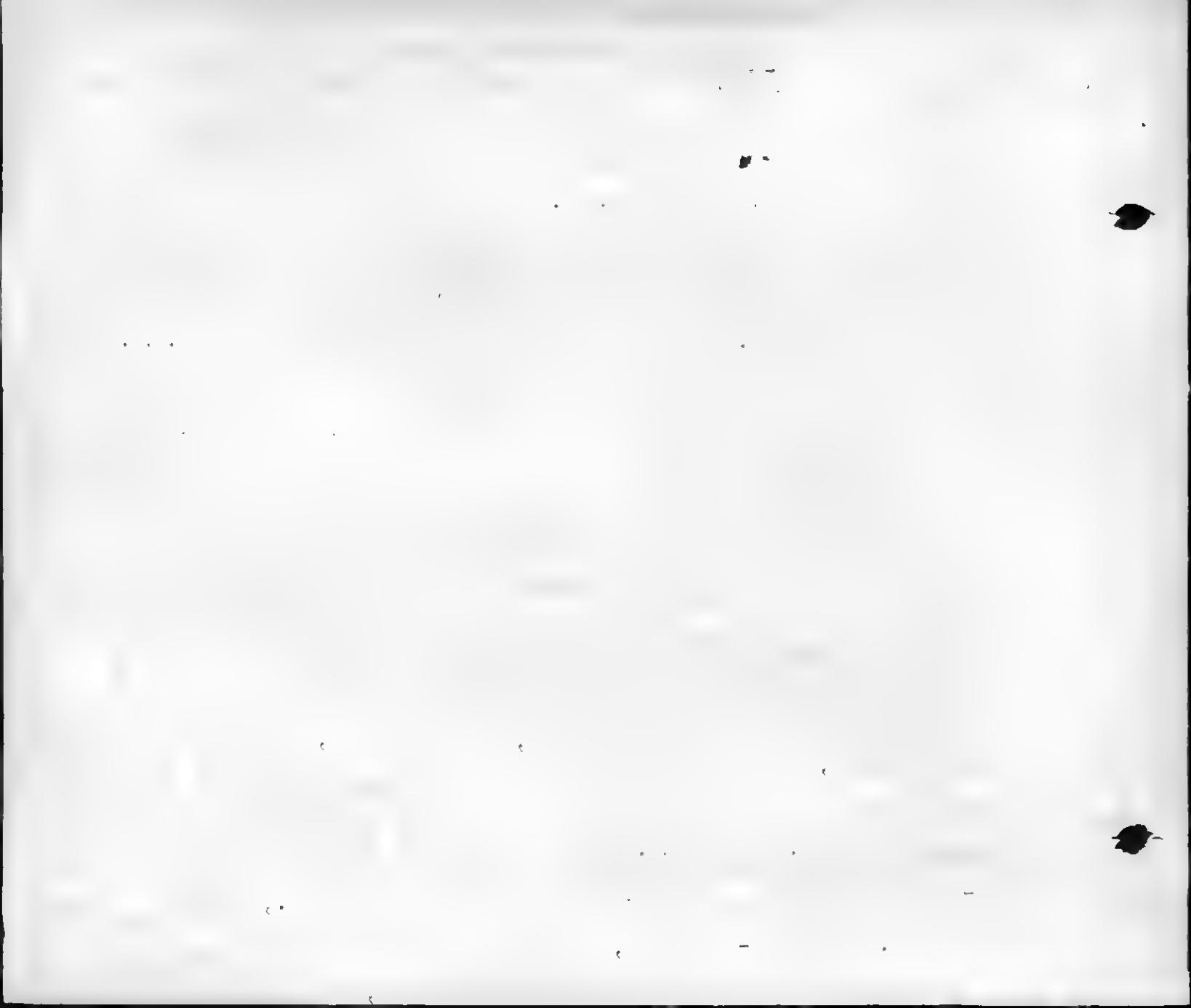
## 4813 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 62 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tallahassee				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #2, Box 601		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First Hayden	Middle James	Last McKenzie	4. DATE OF DEATH April 29, 1958	Month April	Day 30	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 29, 1914	C. AGE (In years last birthday) 44 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Technical Ass't.		10b. KIND OF BUSINESS OR INDUSTRY Public Health		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Hayden McKenzie			14. MOTHER'S MAIDEN NAME Martha Frierson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT The Medical Record Address unavailable		The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 140.4		Cerebral Metastases (symptomatic)					INTERVAL BETWEEN ONSET AND DEATH 72 Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		Malignant Melanoma					21 Months	
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from February 27, 1958, to April 30, 1958, that I last saw the deceased alive on April 30, 1958, and that death occurred at 3:45 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE <i>Dane R. Boggs</i> M.D.								
DATE SIGNED 5/1/58								
PHYSICIAN'S NAME (Type) DANE R. BOGGS, M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland						
22a. BURIAL CREMATION Burial Transit 5/1/58		22b. DATE THEREOF 5/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Oakland		22d. LOCATION (City, town, or county) Leon Co., Florida (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 5 '58	24b. REGISTRAR'S SIGNATURE <i>Alv Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04792

Reg. Dist. No.

4814

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
Montgomery		a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Cherry Chase		Md Monty	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
7 hrs		Cherry Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
5610 Warwick Rd		5514 Cedar Parkway	
e. IS RESIDENCE ON A FARM?			
3. NAME OF <small>(Type or print)</small>		e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First: Guy		Middle: McPherson	
3. SEX		4. DATE OF DEATH	
Male		Month: Apr Day: 25 Year: 1958	
6. COLOR OR RACE		5. SEX	
White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		12-28-82	
DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
nanny saps		Personal	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Wash. D.C.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Robert McPherson		Mary Spearling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INTERMENT	
Dorothy McPherson - San Fran 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
4 Coronary occlusion			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
Cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
FRANK J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4-25-58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		4/29/58	
22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS		22d. LOCATION (City, town, or county) (State)	
Glenwood Cemetery		Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR APR 30 '58	
Robert A. Pumphrey Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE A. J. Broschart	

LIBRARY

APR 20 1959

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04793

4815

## CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b>		COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>4222 River Road, N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Baby</b>	Middle <b>Boy</b>	Last <b>MERRITT</b>	4. DATE OF DEATH <b>April</b>	Month <b>15</b>	Day <b>1958</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12 April 1958</b>	9. AGE (In years last birthday) yrs. <b>3</b>	10. IF UNDER 1 YEAR Months <b>3</b>	11. IF UNDER 24 HRS Hours <b>0</b>	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY: <b>U.S.</b>	
13. FATHER'S NAME <b>Handall G. MERRITT</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Frances CALOWOR</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Official Navy Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Agmen</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Prematurity (23 week gestation)</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 April 1958</b> , to <b>15 April 1958</b> , that I last saw the deceased alive on <b>14 April 1958</b> , and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Kenneth W. Sell</b> M.D. U.S. Naval Hospital, Bethesda, Md. 4-17-58 DATE SIGNED							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>Kenneth W. SELL, LT, MC, USN</b> U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-21-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chambers, 3072 "M" St. N.W., Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>APR 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alv. edue</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be refiled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU U. S.

APR 18 1963

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114794

4778

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

## c. LENGTH OF STAY IN 1b

4 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

7911 Garland Ave.

## 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

7 Takoma Park

## d. STREET ADDRESS

7911 Garland Ave.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
LORANEMiddle  
ASHMANLast  
MIERLEY4. DATE  
OF  
DEATHMonth  
AprilDay  
4  
Year  
1958

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED 

## 8. DATE OF BIRTH

4/8/83

9. AGE (In years  
last birthday)74  
yrs.10. US  
IF UNDER 1 YEAR  
Months  
Days11. IF UNDER 24 HRS  
Hours  
Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Farmer

## 10b. KIND OF BUSINESS OR INDUSTRY

Farmer

## 11. BIRTHPLACE (State or foreign country)

Pennsylvania

## 12. CITIZEN OF WHAT COUNTRY?

US

## 13. FATHER'S NAME

Frank Mierley

## 14. MOTHER'S MAIDEN NAME

Anna Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes or no or unknown)  
(If yes, give war or date of service)

No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT

Mrs. Edith Peterson, Dtr. 7911 Garland Ave.

## Address

Takoma Park, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY-  
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

Acute

4/2/58

## DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

## DUE TO

(b) Hypertensive Heart Disease

5 yrs.

## (c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify medical examiner)

## 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m.  
p. m. 1920d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I attended the deceased from July 1956 to April 1958, that I last saw the deceased alive on April 2, 1958, and that death occurred at 4:20 A.M. from the causes and on the date stated above.

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

ERNEST A. SARAO

ADDRESS (Street, city or town, state)

DATE SIGNED

7006 NEW HAMPSHIRE Ave April 9, 1958

## 22a. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

4/7/58

## 22c. NAME OF CEMETERY OR CREMATORIUM

Ft. Lincoln Cemetery

## 22d. LOCATION (City, town, or county)

Prince George County, Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Warren E. Humphrey, 9434 Ga. Ave. Sil. Sp. Md.

## 24a. REC'D BY REGISTRAR

APR 7 50

## 24b. REGISTRAR'S SIGNATURE

Albermarle

RECEIVED

APR 7 1958

V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04795

## 4816 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>433 Southwest Dr.</b>		d. STREET ADDRESS <b>433 Southwest Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>PAUL</b>		First <b>F.</b>	Middle <b>.MCORE, SR</b>	4. DATE OF DEATH <b>April 4 1958</b>	Month <b>April</b>	Day <b>4</b>	Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1892</b>	9. AGE (In years lost birthday) <b>66 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>2</b>		Days <b>21</b>	Hours <b>11</b>	Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hardware</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>				
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>		17. INFORMANT <b>Eleanor I Moore</b>	Address <b>same as 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Hypertensive-Cardio-renal</b> (c) <b>-vascular disease</b>										[INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>442 W. 10th St.</b>		(County) <b>Baltimore</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct. 13, 1947, to April 4, 1958</b> , that I last saw the deceased alive on <b>April 4, 1958</b> , and that death occurred at <b>442 W. 10th St.</b> from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>Lester W. Harris</b>		ADDRESS (Street, city, town, state) <b>10111 Colesville Rd</b>								
PHYSICIAN'S NAME (Type) <b>Lester W. Harris</b>		DATE SIGNED <b>4-4-58</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Parklawn</b>		22d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		ADDRESS <b>10111 Colesville Rd</b>		24a. REC'D BY REGISTRAR <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rel. - ?</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 7 1928

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4817

## CERTIFICATE OF DEATH

04796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>18 hrs. 45 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. STREET ADDRESS <b>10114 Parkwood Terrace</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Frances</b>		First <b>C</b>	Middle <b>C</b>	Last <b>Morris</b>	4. DATE OF DEATH <b>April 10 1958</b>	Month <b>April</b>	Day <b>10</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1891</b>	9. AGE (In years last birthday) <b>66</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. MIN. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A. - Person</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William McEravney</b>		14. MOTHER'S MAIDEN NAME <b>Ida May Hepp</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Survivor</b>		Address <b>SAME</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension Heart Disease</b> DUE TO <b>26ax</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Hypertension</b> (c) DUE TO <b>Diabetic Mellitus</b>				<b>15 yrs</b>		
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from _____, 1958, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at _____ A.M. from the causes and on the date stated above. <b>Merton L. White</b>		ADDRESS (Street, city or town, state) <b>M.D. 11134 Georgia Ave. Silver Spring, Md 10415</b>				DATE SIGNED <b>4/14/58</b>		
22a. PHYSICIAN'S NAME (Type) <b>Merton L. White</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>				22d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>		
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Walsh</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** Item 11 Film G228 5-15-58 et 114797  
**4818 CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b>		Reg. Dist. No.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Md.</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		b. COUNTY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alta Vista Rest Home</b>				d. STREET ADDRESS <b>4616-48th St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ELIZABETH</b>	Middle	Last <b>MOWBRAY</b>	4. DATE OF DEATH <b>April 27</b>	Month Day Year <b>1958</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1881</b>	9. AGE (In years lost birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>George Poole</b>		14. MOTHER'S MAIDEN NAME <b>Mary Evans</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Rest Home records</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  + Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)  DUE TO  DUE TO (c)  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Acute Heart Failure   10 min. Congestive Heart Failure   1 yr. Atrial fibrillation Heart Dis.   1 yr.									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5532 Greentree Ave	20f. (City or town) Baltimore	(County)	(State)		
21. I certify that I attended the deceased from <b>Oct 1, 1956</b> to <b>April 27, 1958</b> , that I last saw the deceased alive on <b>April 24, 1958</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>5532 Greentree Ave</b>	DATE SIGNED <b>A. H. Richwine</b>
ACTUAL SIGNATURE <b>A. H. Richwine</b>		PHYSICIAN'S NAME (Type) <b>A. H. Richwine</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/30/58</b>	22b. DATE THEREOF <b>4/30/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cherry Chase Forest Home</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>	23a. REC'D BY REGISTRAR <b>APR 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Off. of Health</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Forest Home</b>		ADDRESS <b>5532 Greentree Ave</b>		24a. REC'D BY REGISTRAR <b>APR 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Off. of Health</b>				

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RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4709 CERTIFICATE OF DEATH

Reg. Dist. No.

04798

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>1/2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gilbert Drayton Mulkey</i>		First	Middle
4. DATE OF DEATH <i>4-6-58</i>		Month	Day
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>2-2-84</i>		9. AGE (In years lost birthday) <i>74</i>	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Steel Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital Records</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USAmerica</i>		13. FATHER'S NAME <i>Joseph Mulkey</i>	
14. MOTHER'S MAIDEN NAME <i>Missouri Johnson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>420-1</i>		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Complete Heart Block</i>		INTERVAL BETWEEN ONSET AND DEATH <i>few min.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Embolism (Bifurcation of aorta)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar. 24, 1958</i> , to <i>4-6-58</i> , that I last saw the deceased alive on <i>Apr. 5, 1958</i> , and that death occurred at <i>4:52 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1600 Carroll Ave.</i>	
ACTUAL SIGNATURE <i>Paul V. Starr</i>		DATE SIGNED <i>4-6-58</i>	
PHYSICIAN'S NAME (Type) <i>W.W. Chambers, C. L. Carroll, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>4-8-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodlawn Mem. Pk.</i>		22d. LOCATION (City, town, or county) <i>Bluefield, W. Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers, C. L. Carroll, Md.</i>		ADDRESS <i>5801 Cleveland Ave.</i>	
		REC'D BY REGISTRAR <i>APR 8 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Albert E. ...</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it at once, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4724 Montgomery Rockville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE		Md Rockville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Fall Rd		d. STREET ADDRESS		Fall Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First George	Middle Surber	Lost	4. DATE OF DEATH	Month Apr	Year 3 19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last b. day)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept 15 76	8 yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife				W. Va		St. S. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Geo. H. Surber		Rose Hillary					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT		Address 4836 Brooklynn Dr Bethesda, Md	
No		Unknown		Roberber Miller		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4 v.v.</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.							
DUE TO <u>b</u> DUE TO <u>c</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broeschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-3-58					
EXAMINER'S NAME (Type) <u>FRANK J BROESCHERT</u>							
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-58		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery		22d. LOCATION (City, town, or county) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE <u>Debra Smith</u>	

BUREAU V. S.

APR 7 1959

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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4820

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>1500 Arlington Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Jean</b>	Middle <b>Murray</b>	Last <b>NIELSEN</b>	4. DATE OF DEATH <b>April</b>	Month <b>15</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7 Oct. 1904</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS Days <b>3</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manicurist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Percy Sudsbury</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Goudet</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>(Husband) James NIELSEN (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, acute</i>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 April</b> , 1958, to <b>15 April</b> , 1958, that I last saw the deceased alive on <b>15 April</b> , 1958, and that death occurred at <b>8:55 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-16-58</b>							
ACTUAL SIGNATURE <i>Robert G. Muth</i>							
PHYSICIAN'S NAME (Type) <b>Robert G. MUTH LT MC USN</b> U.S. Naval Hospital, Bethesda, Md. 4-16-58							
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Chambers</i> Chambers, 3043 "M" Street, N.W. Washington, D.C.				ADDRESS		24a. REC'D BY REGISTRAR <b>APR 18 '58</b>	
						24b. REGISTRAR'S SIGNATURE <i>Alfred J. Schuck</i>	

BUREAU V. S.

18 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4821 : CERTIFICATE OF DEATH

Reg. Dist. No.

04802

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>70 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seanol</b>		d. STREET ADDRESS <b>Box 302</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Stephen</b>	Middle <b>Emery</b>	Last <b>Orosz</b>	4. DATE OF DEATH <b>April</b>	Month <b>20</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>September 29, 1950</b>	9. AGE (in years last birthday) <b>7 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USLAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Emery S. Orosz</b>				14. MOTHER'S MAIDEN NAME <b>Mary Sepety</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>204.3</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Acute leukemia</b> DUE TO <b>1 yr.</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>February 9, 1958</b> , to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 20, 1958</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>Kurt W. Kohn</b>							
ACTUAL SIGNATURE	M.D. <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>						
PHYSICIAN'S NAME (Type)	<b>Kurt W. Kohn, M. D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>	22b. DATE THEREOF <b>4-24-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Marys Greek Catholic</b>	22d. LOCATION (City, town, or county) <b>Windber, Pa.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>	ADDRESS <b>Bethesda, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 23 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred J. Schuch</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

BUREAU Y.  
RECEIVED

APR 13 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04803

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 8 & 9, File # 228 4/21/58.cac			
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u>		<b>7. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)</b> b. STATE <u>Md</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
<b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <u>Silver Spring</u>		<b>c. LENGTH OF STAY IN 1b</b> <u>3 1/2 yrs</u>	
<b>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</b> <u>3307 Fairthng Dr.</u>		<b>e. STREET ADDRESS</b> <u>3307 Fairthng Dr.</u>	
<b>3. NAME OF DECEASED (Type or print)</b> <u>George Christie Otto</u>		<b>4. DATE OF DEATH</b> <u>Apr 11 1958</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OF RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1901-5-30-1119 P.D.L.</u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Mailman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>auto</u>	
<b>11. BIRTHPLACE (State or foreign country)</b> <u>Ind.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)</b> <u>yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>WW #2 217-05-7847</u>		<b>17. INFORMANT</b> <u>Sadie Otto (wife) Name # 2</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>420.1</u> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (b)</b> <u>(a), stating the underlying cause last.</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u>	
<b>DUE TO</b> <u>(c)</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>While of work</u>	
<b>20c. TIME OF INJURY</b> Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b> <u>Arlington</u> <b>(County)</b> <u>(State)</u>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>		<b>DATE SIGNED</b> <u>Apr 12 - 1958</u>	
<b>22a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>4/15/58</u>	
<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <u>Arlington Nat'l. Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Virginia</u> <b>(State)</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warren S. Humphrey</u>		<b>ADDRESS</b> <u>Silver Spring, Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>APR 15 1958</u>		<b>24b. REC'D STAR'S SIGNATURE</b> <u>Alt. each</u>	

BUREAU V.

APR 15 1963

REGIME

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04804

4823

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARIETTA		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Washington</b>		b. COUNTY <b>D. C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 days.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		d. STREET ADDRESS <b>5411 Nebraska Ave. N. W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Florence</b>		First <b>E.</b> Middle <b>Painter</b>		4. DATE OF DEATH <b>April 27 1958</b>		Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/2/83</b>		9. AGE (In years lost birthday) <b>74</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>EDWARD HAUSER</b>		14. MOTHER'S MAIDEN NAME <b>Henrie ta <del>Hausser</del> RAU</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Son</b> <b>Rolen H. Painter</b>		Address <b>5411 Nebraska Ave, NW Washington, D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>IX</b>		DUE TO <b>INTERNAL CEREBRAL INFARCTION, LENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>CEREBRAL VASCULAR SCEROSIS</b>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 5000 Reno Rd Ha</b>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1956</b> to <b>April 27, 1958</b> , that I last saw the deceased alive on <b>April 26, 1958</b> , and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>4/27/58</b>			
ACTUAL SIGNATURE <b>W. Fleet Luckett</b>									
PHYSICIAN'S NAME (Type) <b>W. FLEET LUCKETT</b>		5000 Reno Rd., N.W., Washington, D. C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-30-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BUREAU V.

APR 1960

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 M1mG228 5-9-58 et  
4824 CERTIFICATE OF DEATH

04805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14816 Dorset Ave.</b>		d. STREET ADDRESS <b>14816 Dorset Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>THEODOSTA</b>	Middle <b>W.</b>	Last <b>PALMER</b>	4. DATE OF DEATH <b>April 26 1958</b>	Month <b>April</b>	Day <b>26</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 8, 1894</b>	9. AGE (in years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b>	Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maret School</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Walter</b>				14. MOTHER'S MAIDEN NAME <b>Amalie Ann Hutton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-48-7471</b>		17. INFORMANT <b>Richard C. Palmer, (Son)</b>		Address <b>Pompton Plains, N.J.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus</b> DUE TO 215X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Endometrial carcinoma</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 26</b> , 1958, to <b>Apr. 26</b> , 1958, that I last saw the deceased alive on <b>Apr. 26</b> , 1958, and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas L. Hartman M.D.</b> ADDRESS (Street, city or town, state) <b>1834 Eye St., N.W., Wash. D.C.</b> DATE SIGNED <b>Apr. 26, 1958</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Apr. 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedars Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bethesda, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Funeral Home</b>		ADDRESS <b>5103 May Ave. N.W.</b>		24a. REC'D BY REGISTRAR <b>PR 30 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Alberbach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and impayable within 72 hours after death.

BULEAU V. S

APR 1972

PEGEIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4825

Item 9 File #22851252

04808

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN lb <b>14 Mo. about</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>		d. STREET ADDRESS <b>6002 43rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>FLORENCE</b>		First <b>EUGENIA</b>	Middle <b>PARKETT</b>	Last <b></b>	4. DATE OF DEATH <b>April 20 1958</b>	Month <b>April</b>	Day <b>20</b>	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1876</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Thomas J. Linthicum</b>				14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Asbury Methodist Home Gaithersburg, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b> <b>33IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension + 4</b> DUE TO (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arthritis, obesity</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Colmar Manor, Md.</b>		(County) <b>Montgomery Co.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>9-25</b> , 19 <b>57</b> , to <b>4-20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-16</b> , 19 <b>58</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4208 Anthony ST Henshaw, Taylorsville, Md.</b>									DATE SIGNED <b>4-20-58</b>
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/13/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				ADDRESS		24a. RECD BY REGISTRAR DATE <b>APR 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>L. Reuben</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

DECEMBER

APR 20 19

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4826

## CERTIFICATE OF DEATH

Reg. Dist. No.

14807

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		Maryland	
Silver Spring		2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Le Deau Gardens		d. STREET ADDRESS	
Victor Cox		Middle	Lost	4. DATE OF DEATH	Month Day Year
3. NAME OF DECEASED (Type or print)	First	Pedersen		April 9,	1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11/15/1867	90 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Physician, retired		Doctor		New York City, N. Y.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Silvey Pedersen		Victoria Cox		Address 9909 Thornwood Rd Kensington, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter	
Yes NYI		None		Mrs. Walter P. Warendorff	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure 3-4 days			
450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO			
{ (b) Anoxia due to respiratory & circulatory decompensation		Yrs			
{ (c) Severe		Yrs			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1958, to Apr 8, 1958, that I last saw the deceased alive on Apr 5, 1958, and that death occurred at 9:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		DATE SIGNED			
PHYSICIAN'S NAME (Type)		SAMUEL ALLEN			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIALy	
Cremation		4/14/58		Cedar Hill Crematory	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Robert A. Rumsey Bethesda, Maryland				DATE 1958 4 14 '58	
				24b. REGISTRAR'S SIGNATURE	

SAU V. S

1958

SAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04808

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4827		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Montgomery MARYLAND				b. STATE Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Chevy Chase 21 yr				Chevy Chase		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		4612 Harrison St		
4612 Harrison St.						
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year	
Martha Stewart Phillips				Apr 19	1958	
5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	
Female		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	Sept 19, 1901	56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
House maker				Maine		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
John W. Stewart		Martha (SAFFORD) Stewart		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		
				Geo R. Phillips - husband		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
DUE TO Acute Congestive heart failure sudden						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
(b) Chronic cardio-renal disease 1 yr						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED
EXAMINER'S NAME (Type)		Frank J. Broschart				4-19-58
22a. BURIAL OR CREMATION (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Branchville, New Jersey (State)
Cremation (Specify)		4/20/1958				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE C. L. Gedrich
Joseph Hawley's Sons, Washington, D. C.				DATE		

BUREAU V. S.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04809

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.



If any delay is necessary, please execute if certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4828		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Montgomery</i>		MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
wheaton		7 mo		Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
12619 Farnell Dr		12619 Farnell Dr		g. DATE OF DEATH Month Day Year	
3. NAME OF DECEASED (Type or print)		First	Middle	Month	Day
Walter Taylor Postzeman				Apr	19
4. DATE OF DEATH		Month	Day	Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 16 YEARS Months Days Hours Min.
Male White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-5-1905	52	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Jeweler				Washington DC	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John H. Postzeman		Ginnie Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(Yes, No, or Unknown)				Josephine Postzeman (wife) Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive heart failure		sudden	
2044		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)	Lentisuria	3 yrs	
(c)		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Borschert</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-19-58			
EXAMINER'S NAME (Type) <i>FRANK J. Borschert</i>					
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF ADDRESS Timothy Hanlon Funeral Home, Wash. 11, D.C.		22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET	
22d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE VS A15ME SM 2 '57		24. REC'D BY REGISTRAR DATE APR 22 '58 REGISTRAR'S SIGNATURE A. L. Smith			

BUREAU V. S.

AP3

REGEVILLE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04810

4829

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY <b>Montgomery</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE <b>Maryland</b> Ohio b. COUNTY <b>XXXXXXX Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park Dayton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>1740 King Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Mark</b>		First <b>Alvin</b>	Middle <b>Poff</b>	4. DATE OF DEATH <b>April 16 1958</b>	Month Day Year
5. SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>13 April 1958</b>	9 AGE (in years from birthday) yrs <b>3</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Ralph Mark Poff</b>		14. MOTHER'S MAIDEN NAME <b>Carol F. PRYOR</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(Father) Ralph M. Poff (Same As #2)</b>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Disease</b> DUE TO (c) <b>10 min</b> <b>3 days.</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Complete stenosis of Pulmonary artery - Overriding Aorta + Patent Ductus</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of line 18.) <b>Patent Ductus</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 April 1958</b> to <b>16 April 1958</b> that I last saw the deceased alive on <b>16 April 1958</b> , and that death occurred at <b>2:21 PM</b> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-17-58</b>					
ACTUAL SIGNATURE <b>Kenneth W. Sell</b>					
PHYSICIAN'S NAME (Type) <b>Kenneth W. Sell, LT, MC, USN</b> U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-22-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodland Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Dayton, Ohio</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 21 '58</b>	
VS A15 (4) ISM 10/57				24b. REGISTRAR'S SIGNATURE <b>W.L. 2211</b>	

2,512,185

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

APR 2 1958

DECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be relied upon by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 04811	
4830 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		c. LENGTH OF STAY IN 1b 25 days		a. STATE Pennsylvania		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Philadelphia 15			
3. NAME OF DECEASED (Type or print)		First Deborah	Middle (None)	Last Pollock	4. DATE OF DEATH April	Month	Day	Year	d. STREET ADDRESS 1823 Benson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX		6. COLOR OR RACE Female White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 18 April 1936		9. AGE (In years last birthday) 21 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Clerk Typist		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Leon Pollock		14. MOTHER'S MAIDEN NAME Sally Zlotnick									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac arrest				0					
229X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Dental debility				1 week					
DUE TO (b)		Tertocarcinoma				5 months					
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from March 9, 1958, to April 3, 1958, that I last saw the deceased alive on April 3, 1958, and that death occurred at 5:53 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>Allen D. Goodman</i>		M.D.		The Clinical Center		DATE SIGNED 4/3/58					
PHYSICIAN'S NAME (Type) Allen D. Goodman, M. D.				National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Montefiore		22d. LOCATION (City, town, or county) Philadelphia (State) Penns					
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Jasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Date APR 7 '58		24b. REGISTRAR'S SIGNATURE <i>C. Schreiber</i>					

BUREAU V. S.

7 1959

REVIEWED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4831

## CERTIFICATE OF DEATH

04812

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Louisiana</b>		b. COUNTY <b>Calcasieu</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>69 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maplewood</b>		d. STREET ADDRESS <b>115 Madison Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Winnie</b>	Middle <b>Rose</b>	Last <b>PRINE</b>	4. DATE OF DEATH <b>April 26 1958</b>	Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 October 1933</b>	9. AGE (in years last birthday) <b>24 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>BOLLICH, Peter J.</b>		14. MOTHER'S MAIDEN NAME <b>FRYE, Lottie</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT (Husband) <b>Bennon L. PRINE</b>		Address <b>Falls Church, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>154X Adenocarcinoma Rectum with Metastasis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 Years</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 February 1958</b> , to <b>26 April 1958</b> , that I last saw the deceased alive on <b>26 April 1958</b> , and that death occurred at <b>3:40 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Bethesda, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <i>R. J. Cales</i>							
PHYSICIAN'S NAME (Type) <b>R. J. CALES, LCDR MC USN</b> U. S. Naval Hospital, Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Unknown</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mowata</b>		22d. LOCATION (City, town, or county) (State) <b>Bunice, Louisiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Phumphrey</i>		ADDRESS <b>R. A. Phumphrey, 7557 Wisconsin Ave. Bethesda,</b>		Md.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <i>Alleschuk</i>
						<b>APR 29 '58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the original with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

BUREAU Y.

APR 28 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4710

## CERTIFICATE OF DEATH

Reg. Dist. No.

04814

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
<i>Montgomery</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Takoma Park</i>		3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
<i>Washington San + Hospt.</i>		<i>611 Thayer Ave.</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Howard</i>		<i>Ellwood</i>	<i>Ray</i>
4. DATE OF DEATH		Month	Day
		<i>April</i>	<i>21</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
<i>Male</i>		<i>White</i>	<i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
<i>5/28/20</i>		<i>37 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Cab Driver</i>		<i>Self employed</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U. S. A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James Ray</i>		<i>Beatrice Bowman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
<i>Yes</i>		<i>578-18-7596</i>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
<i>32x2</i>		<i>Acute hemorragic pancreatitis</i>	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
<i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		<i>5-12 hours</i>	
(b) <i>Alcoholism</i>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>4/19/58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/14/58</i> to <i>4/21/58</i> , that I last saw the deceased alive on <i>4/21/58</i> , and that death occurred at <i>7:45 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thomas G. Edison Md. 4/25/58</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Brookville, Md. April 25, 1958</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS G. EDISON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <i>4/24/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL Church Cemetery		22d. LOCATION (City, town, or county) (State) <i>Brookville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Pumphrey, Silver Spring, Md.</i>		24a. REC'D BY REGISTRAR DATE APR 24 '58	
		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

SEREAU V. S.

APR 21 1968

DEGEIVILLE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

(4815)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
4711 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		b. COUNTY <b>Prince Georges</b>	
c. LENGTH OF STAY IN 1b <b>Take care Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. San. &amp; Hosp.</b>		d. STREET ADDRESS <b>6612 - 24th Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Florence</b>		First <b>Marie</b>	Middle <b>Nemington</b>
4. DATE OF DEATH <b>April 11 - 1958</b>		Month <b>April</b>	Day <b>11</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11-29-1892</b>		9. AGE (in years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Paul McKay</b>		14. MOTHER'S MAIDEN NAME <b>—</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Miss Mildred L. Nemington - time.</b>	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 45 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INTERVAL BETWEEN ONSET AND DEATH 6 hr. years</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>Apr 11 1958</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHEART</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 15, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland</b>	24a. REC'D BY REGISTRAR <b>APR 14 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>C. L. S.</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

YANKEE

1339

DEAD

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4712 CERTIFICATE OF DEATH**

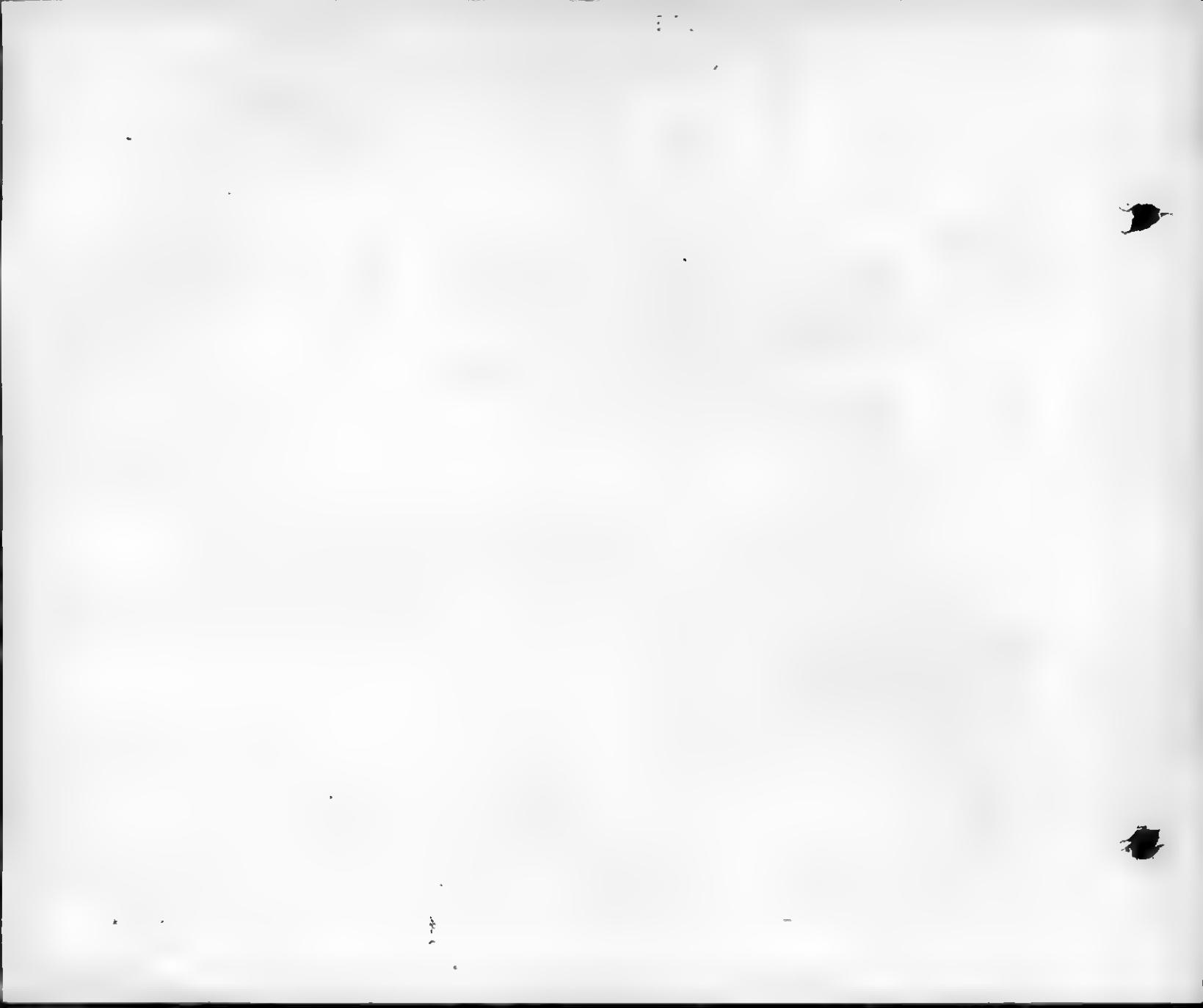
04816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>36 hrs - 15 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda 14+</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital 5 Russell Rd</i>		d. STREET ADDRESS <i>5 Russell Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>David</i>	Middle <i>Barbour</i>	Last <i>Richardson</i>	4. DATE OF DEATH <i>April 29 1958</i>	Month <i>Apr</i>	Day <i>29</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>April 28 1951</i>	9. AGE (In years from birthday) yrs <i>7</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours Min <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>Alvin Charles Richardson</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Blanche Maye</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>000</i>		17. INFORMANT <i>Fried</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Atelectasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>Silver Spring Md. Montgomery County Maryland</i>	
21. I certify that I attended the deceased from <i>4-28</i> , 1958, to <i>4-29</i> , 1958, that I last saw the deceased alive on <i>4-29</i> , 1958, and that death occurred at <i>7:35 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>Silver Spring Md.</i> DATE SIGNED <i>4-29-58</i>							
MEDICAL CERTIFICATION							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>							
22b. DATE THEREOF <i>4-30-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Sanitarium and Hospital</i>		22d. LOCATION (City, town, or county) <i>Takoma Park, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roger Coffey M.D.</i>							
ADDRESS <i>Washington Sanitarium and Hosp</i>				24a. REC'D BY REGISTRAR <i>MAY 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albert E. Schuch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04817

4832

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 16 <b>35 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Norman</b>	Middle <b>Francis</b>	Last <b>Ridgeway</b>
4. DATE OF DEATH <b>April 23</b>	Month <b>April</b>	Day <b>23</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1935</b>
		9. AGE (In years last birthday) <b>23</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Wesley N. Ridgeway</b>	
14. MOTHER'S MAIDEN NAME <b>Mildred Downey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>	
16. SOCIAL SECURITY NO <b>230-50-9205</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda, 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic anæmia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
19. MEDICAL CERTIFICATION Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Metastatic Herpes zoster</b> (c)		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 19, 1958</b> , to <b>April 23, 1958</b> , that I last saw the deceased alive on <b>April 23, 1958</b> , and that death occurred at <b>5:08 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
DATE SIGNED <b>4/24/58</b>			
ACTUAL SIGNATURE <b>Lawrence Schlachter, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Lawrence Schlachter, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>4-26-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>National Institutes of Health</b>	22d. LOCATION (City, town, or county) <b>Bethesda 14, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.M. Dennis &amp; Son, Alysonia, VA</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '58</b>	
ADDRESS <b>W.M. Dennis &amp; Son, Alysonia, VA</b>		24b. REGISTRAR'S SIGNATURE <b>W. Schaefer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be refiled by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR - 1953

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4833

Item 14 Film 322A 5-15-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

04818

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] b. STATE	
Montgomery MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	Washington, D.C. 111x ✓	
b. ETHESDAE	8 days.	d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	Suburban		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Fredrick	John	Ritter
4. DATE OF DEATH	Month	Day	Year
	April	19	1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 19, 1885
9. AGE (In years last birthday) 12 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
Retired			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Architectural Eng.	Philadelphia, Pa.	Philadelphia, Pa.	USA
13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME	Address	
Henry B. Ritter	Maria Elizabeth Buchlein	Same as above	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT WIFE	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
(If yes, give war or dates of service)		Mrs. Souella Ritter	Bronchopneumonia, bilateral 446X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)	Cirrhosis DUE TO
		(c)	Nephrosclerosis, severe 431X DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from April 6, 1958, to April 19, 1958, that I last saw the deceased alive on April 19, 1958, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state) DATE SIGNED		
Stewart Clapp	M.D. 3921 Ingman St NW, 4-1958		
PHYSICIAN'S NAME (Type)	Wash 15 D.C.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	4/21/58	Parklawn, Crem	Rockville Pike MD
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Cherry Chase Funeral Home Wisconsin	5103	DATE APR 22 '58	Abenrich

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. G

APR 13 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04819

4834

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Md.</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>5104 Emerson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Alfred</b>	Last <b>Roberts</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>8,</b>	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1885</b>	9. AGE (In years lost birthday) <b>72 yrs</b>	IF UNDER 1 YEAR Months <b>72</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Scott Roberts</b>		14 MOTHER'S MAIDEN NAME <b>Amanda Sullivan</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>578-05-7809</b>		17 INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>181.0</b>		DUE TO <i>cardiac arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Metastatic carcinoma of bladder</b>		DUE TO (c) <i>Hypoads oblongans</i>		<b>21 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 29, 19 58</b> , to <b>April 8, 19 58</b> , that I last saw the deceased alive on <b>April 8, 19 58</b> , and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>4/8/58</b>	
ACTUAL SIGNATURE <i>Lawrence Schlachter</i>		M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <b>Lawrence Schlachter, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/10/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>APR 11 58</b>		24b. REGISTRAR'S SIGNATURE <i>Anne L. Schlesinger</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04820

## 4835 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DISTRICT OF COLUMBIA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>4005 FOSSENDEN ST. N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MICHAEL</b>	Middle <b>Anthony</b>	Last <b>Rocca</b>
4. DATE OF DEATH <b>April</b>	Month <b>10</b>	Day <b>10</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7<sup>th</sup> 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FRANK Rocca</b>	
14. MOTHER'S MAIDEN NAME <b>HELEN MAXINE Brown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>Mother</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angiofibroblastosis Fetalis</b> DUE TO <b>Rh incompatibility - (Mother Rh negative)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 7</b> , 1958, to <b>April 10<sup>th</sup></b> , 1958, that I last saw the deceased alive on <b>April 10<sup>th</sup></b> , 1958, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>P.P. Andrews M.D.</b>		ADDRESS (Street, city or town, state) <b>4201 Fessenden St. N.W. Washington, D.C.</b> DATE SIGNED <b>4-10-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) <b>Lovettsville, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Henies Co</b>		24a. REC'D BY REGISTRAR <b>APR 14 1958</b>	
ADDRESS <b>2901-14<sup>th</sup> St. N.W. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Deb. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUAUAU V.  
U.S. NAVY  
1959

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4713 CERTIFICATE OF DEATH

Reg. Dist. No.

04821

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park.</b>		c. LENGTH OF STAY IN 1b <b>10 hours.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>washington Sanitarium &amp; Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter</b>		First <b>(N.MN)</b>	Middle <b>Rodwell</b>
4. DATE OF DEATH Month <b>4</b>		Day <b>15</b>	Year <b>1958</b>
S SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4-19-79</b>
9. AGE (In years last birthday) <b>78 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Retired)</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William Rodwell</b>		14. MOTHER'S MAIDEN NAME <b>Emma Halton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>done</b>		16. SOCIAL SECURITY NO. <b>579-12-6097</b>	
17. INFORMANT <b>Mr. Lawrence W. Mack, 7701 Georgia Ave.</b>		Address <b>Stephens Hosp. Records, Wash. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Congestive Heart Failure</b> DUE TO (c) <b>Atherosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>p. m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) <b>9241 Col. Blvd.</b> (State) <b>M.D.</b>
21. I certify that I attended the deceased from <b>April 14, 1958</b> , to <b>April 15, 1958</b> , that I last saw the deceased alive on <b>April 15, 1958</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4/15/58</b>	
ACTUAL SIGNATURE <b>J. Marion Bankhead</b>		DATE SIGNED <b>4/15/58</b>	
PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/19/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Reynoldsville Cemetery</b>
22d. LOCATION (City, town, or county) <b>Reynoldsville, Pa.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer B. Humphrey, 8134 Georgia Ave.</b>		ADDRESS <b>Silver Spring, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 17 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Allesie</b>	

BUREAU V. S

APR 17 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
**4836**

04822

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

If necessary, please  
execute if certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MD</b>		c. LENGTH OF STAY IN 1b <b>7 HOURS</b>		d. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MARYLAND</b>		f. STREET ADDRESS <b>4404 Fairfield Road Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Getzendanner</b>		First	Middle	Lost	4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1958</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>April 12, 1908</b>	9. AGE (in years last birthday) <b>50</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b> IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Winton Getzendanner</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Gemmill</b>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate poisoning (Seconal)</b> DUE TO Conditions, if any, which goe rise to immediate cause (b) _____ (c) _____ DUE TO (d) _____ (e) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Carcinoma of stomach and intestinal tract</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 15, 1958</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		22b. DATE THEREOF <b>4/16/58</b>			
22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 17 '58</b>			
		24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>			

PEGEV  
BUKZAU V. S.

IPR 17 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4837

## CERTIFICATE OF DEATH

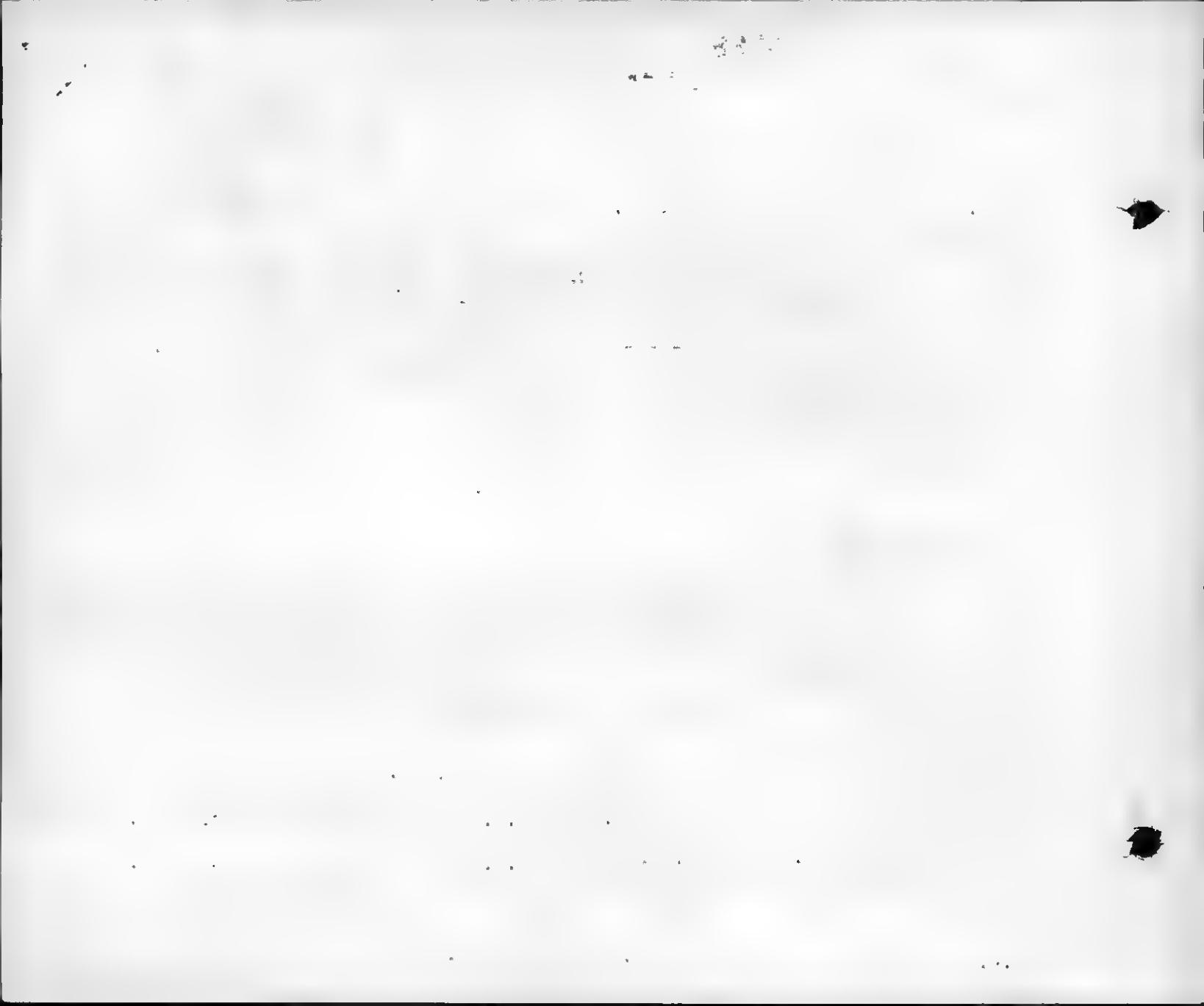
04823  
215.

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be relied upon by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>26-G Riverview Village</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Kathleen</b>	Middle <b>Faye</b>	last <b>RONAN</b>	4. DATE OF DEATH <b>28 Apr 31 1958</b>	Month <b>April</b>	Day <b>30</b>	Year <b>19 58</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>28 Apr 31 1958</b>	9. AGE (In years last birthday) yrs <b>7</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS Hours <b>8</b>	Minutes <b>55</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>Lawrence Edward RONAN</b>				14. MOTHER'S MAIDEN NAME <b>Fernande RIVARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Father) Lawrence E. RONAN (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Prematurity (2260 gms.)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 April 1958</b> to <b>30 April 1958</b> , that I last saw the deceased alive on <b>30 April 1958</b> , and that death occurred at <b>12:30A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Kenneth W. Sell</b> M.D. U.S. Naval Hospital, Bethesda, Md. 4-30-58							
PHYSICIAN'S NAME (Type) <b>Kenneth W. Sell, LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-5-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Catholic Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lewiston, Maine</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>				ADDRESS <b>MAY 5 58</b>		24. REC'D BY REGISTRAR DATE <b>Ali. educh</b>	
25. REGISTRAR'S SIGNATURE							



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4838 CERTIFICATE OF DEATH

04824  
215

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>District of Columbia</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>3 hr. 48 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		47 X - 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>1425 Congress Place, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Michelle</b>	Middle (mmn) <b>(mmn)</b>	Last <b>RUSH</b>	4. DATE OF DEATH <b>April 17 1958</b>	Month <b>April</b>	Day <b>17</b>	Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>17 April 1958</b>	9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS Days <b>3</b>	Hours <b>48</b>		
10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>			
13. FATHER'S NAME <b>Willie L. RUSH</b>				14. MOTHER'S MAIDEN NAME <b>Juanita DEAN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(Father) Willie L. Rush (Same As #2)</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 hr. 48 min.</b>	
776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>b.</b>		DUE TO <b>b.</b>							
DUE TO <b>c.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? <b>NO</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>17 April 1958</b> to <b>17 April 1958</b> that I last saw the deceased alive on <b>17 April 1958</b> , and that death occurred at <b>2:40 P.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	DATE SIGNED <b>4-18-58</b>
ACTUAL SIGNATURE <i>Kenneth W. Sell</i>		U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) <b>KENNETH W. SELL, LT MC USN</b>		U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Bacon Funeral Home</b>		ADDRESS <b>1722 7th St. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>APR 25 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>			

WILZAU V. S.

APR 23 1969

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04825

## 4839 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Arlington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>bethesda</b>		c. LENGTH OF STAY IN lb <b>Suburban Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>2006 Monroe St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Donald</b>		First	Middle	Last	4. DATE OF DEATH <b>April 2 1958</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1888</b>	9. AGE (In years lost/birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR <b>0 months</b>	IF UNDER 24 HRS <b>23 days</b>	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Statler Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13. FATHER'S NAME <b>Donald J. Sanders</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Carter</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Allard J. Sanders-brother</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Anterior Lateral Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>with myocardial infarction</i>				3 days.		
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from alive on		June 1954 to April 2 1958		that I last saw the deceased				
				and that death occurred at 545 W. from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Joseph A. Bailey</b>		ADDRESS (Street, city or town, state) <b>Wash. Clinic, Wash. D. C.</b>		DATE SIGNED				
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Francs</b>		22b. DATE THEREOF <b>4/5/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sunnyside</b>		22d. LOCATION (City, town, or county) (State) <b>Orangeburg, S. C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Lumphrey</b>		ADDRESS <b>bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. E. B. -</b>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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REGIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4840

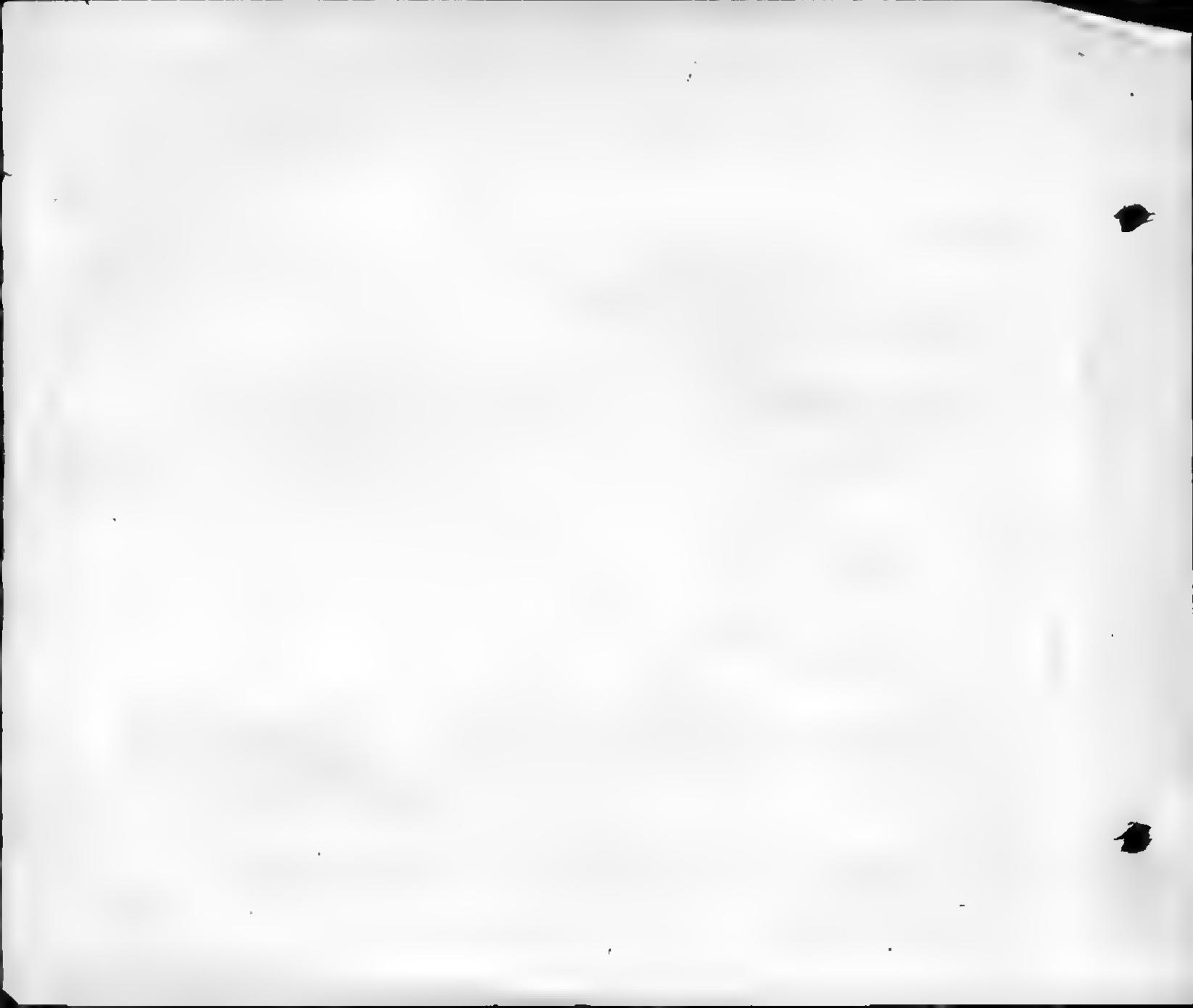
## CERTIFICATE OF DEATH

Reg. Dist. No.

114826

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and if any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Massachusetts</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda MD</i>		c. LENGTH OF STAY IN 1b <i>6 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Waldo Hammond Sargent</i>		First <i>Waldo</i>	Middle <i>Hammond</i>
4. DATE OF DEATH <i>April 29 - 1958</i>		Month <i>April</i>	Day <i>29</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-4-1871</i>
9. AGE (In years last birthday) <i>87 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Boston Mass</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Nelson Sargent</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Ricker</i>	
15. WAS EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Alice Maxwell (daughter)</i>		Address <i>9409 Fernside Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 Hours</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b) DUE TO  (c)		<i>Hypertension Cardiac - Vascular Renal disease Chronic</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none others</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-17-58</i> , 19 <i>58</i> , to <i>4-20-</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-29-58</i> , 19 <i>58</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Frank L. Willman M.D. 2731 Com. Ave NW Wash. D.C.</i>	
ACTUAL SIGNATURE <i>Frank L. Willman</i>		DATE SIGNED <i>4-29-58</i>	
PHYSICIAN'S NAME (Type) <i>Frank L. Willman M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i>	22b. DATE THEREOF <i>4/30/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Lake Grove</i>	22d. LOCATION (City, town, or county) <i>Holliston, Massachusetts</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Unseen</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4841 CERTIFICATE OF DEATH

04827

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				a. STATE Maryland	b. COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 Olney 1 hr. 38 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Montgomery County General Hospital, Inc.		Route #6			
3. NAME OF DECEASED (Type or print)		First Charles	Middle Carroll	Last Schrider	4. DATE OF DEATH Month April Day 27 Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs Months Days Hours Min
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 27, 1958	1 IF UNDER 1 YEAR 38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Newborn				Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Robert Benjamin Schrider		Dorothy Elaine Griffith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Prematurity (2 1/2 lbs)			
761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Placenta abruptio of mother					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 27, 1958, to April 27, 1958, that I last saw the deceased alive on April 27, 1958, and that death occurred at 11:50 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Charles S. Whitaker, M.D.</i>					
PHYSICIAN'S NAME (Type)		C. S. Whitaker, M. D., Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-28-58	22c. NAME OF CEMETERY OR CREMATORIUM Morgan Chapel	22d. LOCATION (City, town, or county) Carroll County, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR APR 29 '58	24b. REGISTRAR'S SIGNATURE <i>Ansreich</i>

BUREAU V. S.

1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4714

## CERTIFICATE OF DEATH

04829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>50 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>washington Sanitarium + Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>(Wheaton) Silver Spring</i>	
f. STREET ADDRESS <i>11403 Monterey Drive</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Emilie</i>		Middle <i>Anna</i>	4. DATE OF DEATH Month <i>April</i> Day <i>2</i> Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/24/97</i> 9. AGE (in years from last birthday) <i>60</i> yrs. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Kirner</i>		14. MOTHER'S MAIDEN NAME <i>Suzanna Kaul</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-12-2066</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Edmund</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		 <i>Cirrhosis of Liver -</i>	
(b) DUE TO <i>8.</i>		 <i>10 years</i>	
(c)		 <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Suppurative Pyelonephritis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Feb 21 1958</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 21, 1958</i> to <i>April 2, 1958</i> , that I last saw the deceased alive on <i>April 2, 1958</i> , and that death occurred at <i>1730</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1730</i> M.D. DATE SIGNED <i>4/2/58</i>	
ACTUAL SIGNATURE <i>H. B. Orleans</i>		PHYSICIAN'S NAME (Type) <i>H. B. ORLEANS, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/4/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l Cemetery</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i> REC'D BY REGISTRAR <i>APR 7 '58</i>	
		24. REGISTRAR'S SIGNATURE <i>Albert Louch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retagged by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 7 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #4 - File #228 - 4/22/58-mb

04830

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

**HOSPITAL OR ATTENDANT PHYSICIAN:** This form requires that the death certificate be executed within 24 hours after death. Page may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if instit on Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>1320 "D" Street, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Franz Xavier SCHUMM</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>April 14 1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 December 1883</b>	9. AGE (In years last birthday) yr. <b>74</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps Band</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Stephen SCHUMM</b>		14. MOTHER'S MAIDEN NAME <b>Anna Maria NICKLAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <b>Yes WW-I</b>		16. SOCIAL SECURITY NO. <b>579 28 6214</b>		17. INFORMANT <b>(Wife) Mrs. Elizabeth A. SCHUMM (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 Days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 April 1958</b> to <b>14 April 1958</b> , that I last saw the deceased alive on <b>14 April 1958</b> , and that death occurred at <b>9:13 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <b>4-15-58</b>	
ACTUAL SIGNATURE <i>G.E. Gorsuch</i>		M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) <b>G.E. GORSUCH, LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Mattingly</i>		ADDRESS <b>Mattingly Funeral Home, 131 11th St. S.E. Wash.D.C.</b>		24a. REGISTRATION NO. <b>APR 18 1958</b>	
				24b. FUNERAL DIRECTOR'S SIGNATURE <i>John Mattingly</i>	

BUREAU V. S.

JUN 18 1959

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4843 CERTIFICATE OF DEATH

Reg. Dist. No.

04828

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <b>Virginia</b>		b. COUNTY <b>Arlington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>1729 South Fillmore Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Hurley</b>	Middle <b>Everett</b>	Last <b>Scott</b>	4. DATE OF DEATH <b>April</b>	Month <b>10</b>	Day <b>19</b>	Year <b>58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>19 November 1957</b>	9. AGE (in years last birthday) yrs. <b>4</b>	10. IF UNDER 1 YEAR Months <b>4</b>	11. IF UNDER 24 HRS Hours <b>22</b>	12. IF UNDER 24 HRS Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel E. Scott</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Martin</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 Hours</b>									
7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Cerebral Anoxia</b> 7 Hours									
DUE TO (c) <b>Congenital Heart Disease, Cyanotic</b> Life									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Cardiac Catheterization 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 6, 1958</b> , to <b>April 10, 1958</b> , that I last saw the deceased alive on <b>April 10, 1958</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>John Waldhausen</i> ADDRESS (Street, city or town, state) M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>JOHN WALDHUSSEN M.D.</b> DATE SIGNED <b>4/11/58</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-14-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Crown Memorial</b>		22d. LOCATION (City, town, or county) <b>Bethesda, Md.</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James C. Chenin</i>		ADDRESS <b>Arlington, Va.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 15 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alt. Leach</i>			

BUREAU V. S.

103 17 193

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 230 6-26-58 a.m.s

04831

## 4844 CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Stanislaus</b>	Middle <b>Joseph</b>	Last <b>SEDLAYWICZ</b>	
4. DATE OF DEATH	Month <b>April</b>	Day <b>14</b>	Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>10 May 1916</b>	
		9. AGE (In years last birthday) <b>41 yrs.</b>		
		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>	11. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy (Retired)</b>	12. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
13. FATHER'S NAME <b>Joseph Sledlaywicz</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-II 220 34-4578</b>	17. INFORMANT <b>Official Navy Records</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melvin Rotner's/Acute Hepatic failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Fatty Liver</i>		Unit		
(c) <i>Chronic Alcoholism</i>		11 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Peritonitis due to Rupture of Bladder</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10 April 1958</b> to <b>14 April 1958</b> , that I last saw the deceased alive on <b>14 April 1958</b> , and that death occurred at <b>11:30P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>		DATE SIGNED <b>4-16-58</b>		
ACTUAL SIGNATURE <i>Melvin Rotner</i>		22. PHYSICIAN'S NAME (Type) <b>Melvin Rotner, LT, MC, USN</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Jones</i>		ADDRESS <b>Chambers, 1400 Chapin St. N.W. Washington, D.C.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 18 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>

HOSPITAL ATTENDANT: The law requires that the death certificate be examined within 24 hours after death: Page 4  
 may be refused by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please render carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in event within 72 hours after death.

PAGE TWO  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04832

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

4715

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 13 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 711 Carroll Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
3. NAME OF DECEASED (Type or print) Katherine		First Shadel	Middle Last 4. DATE OF DEATH April 20, 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9. AGE (In years from birthday) 77 yrs	
13. FATHER'S NAME Holmes		11. BIRTHPLACE (State or foreign country) Wis.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs Hazel Anderson (same as #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.  DUE TO (b)  DUE TO (c)		Address McCloskey	
Coronary occlusion		INTERVAL BETWEEN POUND DEAD IN BED years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschart	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 20, 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 22, 1958	22b. DATE THEREOF April 22, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. John's Evangelical Cemetery	22d. LOCATION (City, town, or county) Hinsdale, Illinois (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter, 711 Carroll St New Wash. D.C.	ADDRESS	24e. REC'D BY REGISTRAR APR 22 '58	24f. REGISTRAR'S SIGNATURE A. L. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

URÉAU V. A

APR 2 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4716 CERTIFICATE OF DEATH

Reg. Dist. No. 04833

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>washington San. &amp; Hosp.</i>		d. STREET ADDRESS <i>119 Sherman Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>Victoria</i>	Middle <i>Beatrice</i>	Last <i>SHARPE</i>	4. DATE OF DEATH Month <i>April</i>	Day <i>12</i>	Year <i>1958</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-3-73</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own Home.</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>						
13. FATHER'S NAME <i>John Moseley</i>		14. MOTHER'S MAIDEN NAME <i>Victoria Adams</i>		Address								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock from Evisceration</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Low tensal strength of fascia</i> DUE TO (b) <i>Malnutrition of Advanced Age</i> DUE TO (c) <i>years</i> <i>years</i>						
19. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>April 1, 1958</i> , to <i>April 12, 1958</i> , that I last saw the deceased alive on <i>April 12, 1958</i> , and that death occurred at <i>1027</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wilfred W. Eastman</i> M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>4/13/1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Augusta, Georgia</i>		22d. LOCATION (City, town, or county) <i>—</i>		(State) <i>—</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gaulers Sons Ward 6, DC</i>		24a. ADDRESS / 752 Pa. Avenue <i>—</i>		24b. REC'D BY REGISTRAR <i>—</i>		24c. REGISTRAR'S SIGNATURE <i>W. Leach</i>						

BUREAU V. S.

APR 15 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4845 CERTIFICATE OF DEATH**

04834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>3 yrs 9 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>9311 E. Parkhill Dr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Rest Home.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Harriet</i>	Middle <i>Vinton</i>	Last <i>Simmons</i>	4. DATE OF DEATH <i>April 18 1958</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5 1872</i>	9. AGE (In years last birthday) <i>85 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>		11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>? Jones</i>		14. MOTHER'S MAIDEN NAME <i>Kate Lecompte</i>		Address <i>Bethesda Md. 20814</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Robert C. Simmons 9311 E. Parkhill Dr.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.1</i>		DUE TO <i>Cerebrovascular Thrombosis</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerotic Cardiovascular Dis</i>		(c)				YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-----</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>58</i> , to <i>APRIL 18 1958</i> that I last saw the deceased alive on <i>APRIL 16, 1958</i> , and that death occurred at <i>6:15 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>DeWitt E. DeLawter</i>				ADDRESS (Street, city or town, state) <i>8025 ABERDEEN Rd. Bethesda Md.</i>		DATE SIGNED <i>4/18/58</i>	
PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLawter, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/21/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>APR 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>R. J. Smith</i>	

BUREAU V.

APR 21 1968

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4717 CERTIFICATE OF DEATH

Reg. Dist. No.

04835

1. PLACE OF DEATH o COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>D.C.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 hrs. 25 min</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		
3. NAME OF DECEASED (Type or print) <i>Leah</i>		d. STREET ADDRESS <i>693 Oglethorpe St., N.E.</i>		
First <i>None</i>		Middle <i>None</i>	Last <i>Simon</i>	
4. DATE OF DEATH <i>4 - 26 - 1958</i>		Month <i>4</i>	Day <i>26</i>	Year <i>1958</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4 - 1 - 10 48</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>
13. FATHER'S NAME <i>Harry Simon</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Feinberg</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Washington Sanitarium &amp; Hospital Records</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Coronary Occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obesity</i>				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 26</i> , 19 <i>58</i> , to <i>April 26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 26</i> , 19 <i>58</i> , and that death occurred at <i>2:25 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Arthur S. Bresler</i>		ADDRESS (Street, city or town, state) DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/28-1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Gro-Wash Memorial Park</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		ADDRESS <i>4217-9½ N.W.</i>		24a. REC'D BY REGISTRAR <i>APR 29 '58</i>
				24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Form 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any case within 72 hours after death.

BUREAU X

APR 22 1963

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4846 CERTIFICATE OF DEATH

04836  
215

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be filed by the hospital or attending physician and completely filled out by the funeral director,**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
**page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with**  
**the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Cynthia</b>	Middle <b>Ann</b>	4. DATE OF DEATH <b>SLAYDEN</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1933</b>		
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>		
13. FATHER'S NAME <b>John Will WHITEHEAD</b>		14. MOTHER'S MAIDEN NAME <b>Jimmie Florence BEAUCHAMP</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO. <b>Not known</b>	17. INFORMANT <b>(Husb) Harold L. Slayden</b>	Address <b>Same as #2 above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hrs.</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertension</b>			10 yrs.		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>March 29, 1958</b> , to <b>April 2, 1958</b> , that I last saw the deceased alive on <b>April 2, 1958</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>F. H. O'Connell</b>					
PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LT, MC, USN</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>755 Wisconsin Ave.</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>R. A. PUMPHREY FUNERAL HOME Bethesda, Md.</b>	
22d. LOCATION (City, town, or county) <b>England</b>		(State) <b>Arkansas</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				24b. REGISTRAR'S SIGNATURE <b>Alfred J. Slayden</b>	

MURÉAU Y.

JPR 7 1959

RECEIVED

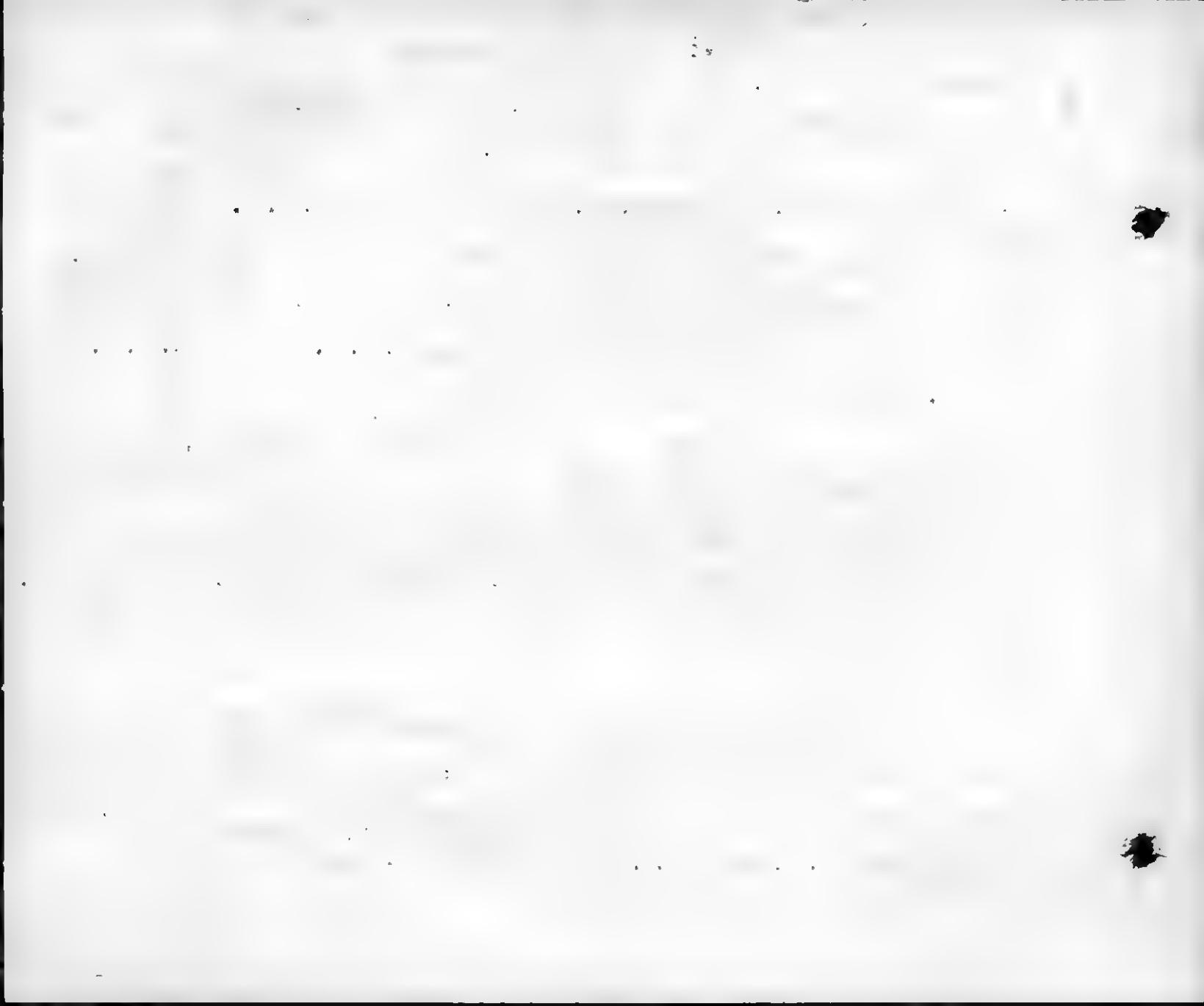
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4847 CERTIFICATE OF DEATH

04837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>26 days</b>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>1019 Irving Street, N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>Donald</b>	First <b>Donald</b>	Middle <b>David</b>	Last <b>Slye</b>
4. DATE OF DEATH <b>April 25</b>	Month <b>April</b>	Day <b>25</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroe</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1956</b>
9. AGE (In years lost birthday) <b>1 yrs.</b>	10. IF UNDER 1 YEAR Months <b>1</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13. IF UNDER 24 HRS Min. <b>0</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John W. Slye</b>	
14. MOTHER'S MAIDEN NAME <b>Velma Dunn</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
19. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (b) <b>Hyper Kalemia</b>		20. DUE TO <b>closure Ventricular Septal</b> 20 Hours	
20. DUE TO <b>Status Postoperative, Defect with Extracorporeal Circulation.</b>		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
22. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
24. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
26. PLACE OF INJURY (Home, farm, 20f (City or town) factory, street, office bldg., etc.) <b>20f (City or town) factory, street, office bldg., etc.</b>		(County) <b>(County)</b> (State) <b>(State)</b>	
27. I certify that I attended the deceased from <b>March 30, 1958</b> , to <b>April 25, 1958</b> , that I last saw the deceased alive on <b>April 25, 1958</b> , and that death occurred at <b>5:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert T. L. Long</i>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT T. L. LONG, M.D.</b>		DATE SIGNED <b>4/26/58</b>	
28. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29. DATE THEREOF <b>4-29-58</b>	
30. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn</b>		31. LOCATION (City, town, or county) <b>Washington, D. C.</b>	
32. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson &amp; Sons 4804 La. AVENUE</i>		33. ADDRESS <b>Johnson &amp; Sons 4804 La. AVENUE</b>	
34. REC'D BY REGISTRAR <b>MAY 1 '58</b>		35. REGISTRAR'S SIGNATURE <i>DeLoach</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

**TO FUNERATOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in envelope within 72 hours after death.

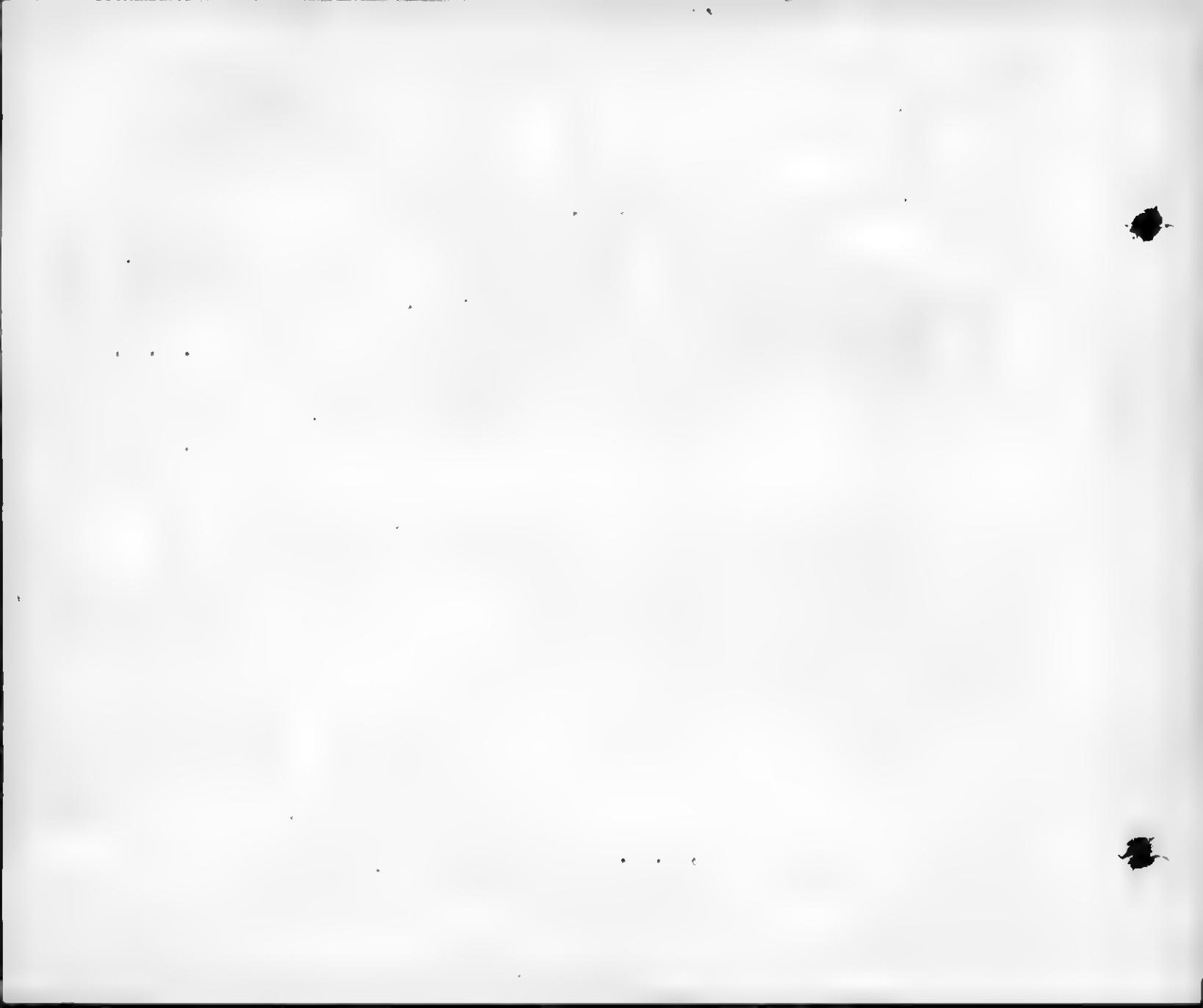
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4848 CERTIFICATE OF DEATH

04838

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>Maryland</b>		COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>		d. STREET ADDRESS <b>405 57th Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Agnes</b>	Middle <b>Gordon</b>	Last <b>Smith</b>	4. DATE OF DEATH <b>April 28, 1958</b>	Month <b>April</b>	Day <b>28</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1887</b>	9. AGE (In years last birthday) <b>71 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>71</b>	Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Package Wrapper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Swanson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Gordon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Methotrexate Toxicity</b> INTERVAL BETWEEN ONSET AND DEATH + 19 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>(therapy for) Malignant Melanoma</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.                          p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 7, 1958</b> , to <b>April 28, 1958</b> , that I last saw the deceased alive on <b>April 28, 1958</b> , and that death occurred at <b>6:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
DATE SIGNED <b>4/29/58</b>							
ACTUAL SIGNATURE <b>Roger Lester</b>							
M.D.							
PHYSICIAN'S NAME (Type) <b>Roger Lester, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bethesda, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers CoDir Washington DC</b>		ADDRESS <b>Washington DC</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Lee L. Smith</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4849 CERTIFICATE OF DEATH

04839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Mont. Co</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Mont.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexington</i>		c. LENGTH OF STAY IN lb <i>14 mos</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8600 Manchester Rd.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Garden Sanitarium</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Alice Moulton Smith</i>		First	Middle	Last	4. DATE OF DEATH <i>4 7 1958</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6 - 16 - 1869</i>		9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Taunton, Mass</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Henry Moulton</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Carpenter</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Margaret Smith 8600 Manchester Rd.</i>		Address <i>JU 5-6895</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>40.0</i>		DUE TO <i>Pulmonary edema.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 hours.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>Arteriosclerotic heart disease.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 years.</i>				
(c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary embolism, remote</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>				
21. I certify that I attended the deceased from <i>June 1956 to April 1958</i> , that I last saw the deceased alive on <i>24 March 1958</i> , and that death occurred at <i>12:10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>929 Pleying River, Silver Spring, Md.</i> DATE SIGNED <i>7 Apr 58.</i>								
ACTUAL SIGNATURE <i>Seruch T. Kimble</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 4/9/58		22b. DATE THEREOF <i>4/9/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>MAYFLOWER HILL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>TAUNTON, MASS.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren L. Lumphey,</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE <i>Reverich</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

APR 9 1953

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04840

## 4850 CERTIFICATE OF DEATH

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 2 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>108 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, NNMC, Bethesda, Md.</b>		d. STREET ADDRESS <b>3020 Porter St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Chandler</b>		First <b>White</b>	Middle <b>Smith</b>	Last <b>SMITH</b>	4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-11-83</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Charles G. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Lloyd White</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>577 50 6952</b>		17. INFORMANT (Wife) Philena P. Smith, same as #2 above Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, multiple</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>302A</b>		DUE TO <b>(b)</b>			
		DUE TO <b>(c)</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County)      (State)	
21. I certify that I attended the deceased from April 2, 1958, to April 9, 1958, that I last saw the deceased alive on April 9, 1958, and that death occurred at 5:35 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>T. S. Dunn Jr.</i>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>4-10-58</b>	
PHYSICIAN'S NAME (Type) <b>T. S. DUNN, JR., LT, MC, USN</b>		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-14-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawler &amp; Sons</i>		ADDRESS <b>1756 Penna. Ave. NW</b>		24a. REC'D BY REGISTRAR DATE <b>APR 11 1958</b>	
				24b. REGISTRAR'S SIGNATURE <i>John E. Conner</i>	

BUREAU Y.

MR 14 1960

BUREAU Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01841

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute it at once, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4851		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c LENGTH OF STAY IN lb 13 days		b. COUNTY Montg.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Marylander Nursing Home		X STREET ADDRESS 9613 Page Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara W Smith		First	Middle	4. DATE OF DEATH April 6, 1958	Month Day Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 9/7/1874	9. AGE IN years 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School matron		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.V.A.	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Cordelia Engel		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Nursing Home Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 6, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 4-4-58, 22c. NAME OF CEMETERY OR CREMATORIUM Norland Cemetery 22d. LOCATION (City, town, or county) Chambersburg, Pa. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barkers Funeral Home Chambersburg Pa.</i>		ADDRESS Barkers Funeral Home Chambersburg Pa.		24a. REC'D BY REGISTRAR APR 9 '58 24b. REGISTRAR'S SIGNATURE <i>Debra L. Deane</i>	

BUREAU V. M.

JPR 9 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04842

Reg. Dist. No.

4718

**1. PLACE OF DEATH**

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL  
and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

10 min

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium + Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

Ralph Francis Smith

April 27 1958

5. SEX

6. COLOR OR RACE

MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

7. DATE OF BIRTH

8. AGE (In years  
last birthday)

49

yrs.

9. IF UNDER 1 YEAR

Months

Days

10. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Salesman.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wash. D.C.

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME

Marshall Smith

14. MOTHER'S MAIDEN NAME

Mary Agnes Archer

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
No

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Mrs. Evelyn Smith—same—wife

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

440.1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Coronary atherosclerosis

INTERVAL BETWEEN  
ONSET AND DEATH

midday

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e. m.  
p. m. 19

20d. INJURY OCCURRED  
While at work  Not while  
at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 4-30-58

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Mc Clellan

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

April 27 1958

22d. LOCATION (City, town, or county)

Wash. D.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Mattingly

ADDRESS

131-11-2184

24a. REC'D BY REGISTRAR

DATE MAY 1 '58

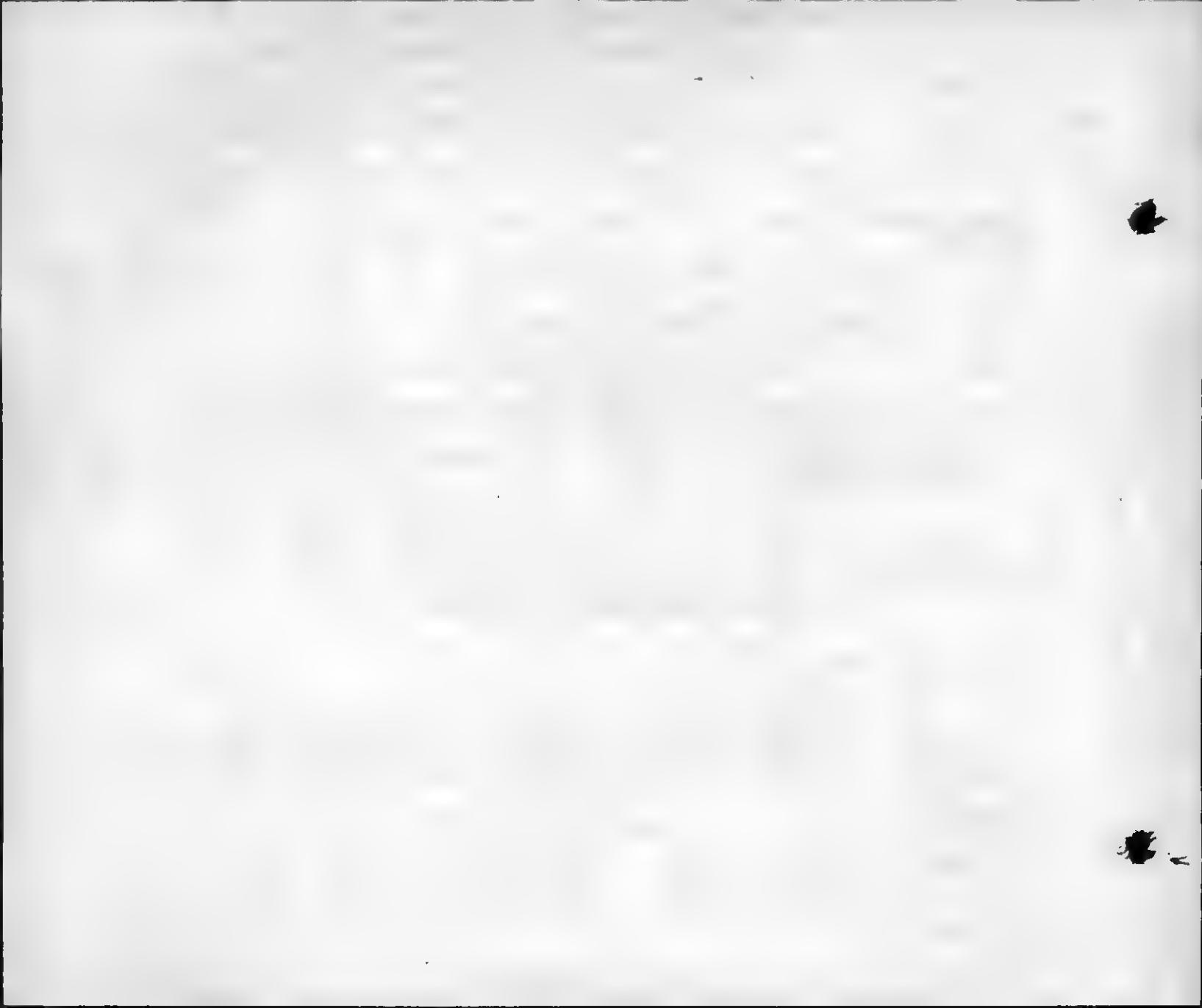
24b. REGISTRAR'S SIGNATURE

Albert E. Seach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
5M 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #8- Film 26 - u 21/58 - nb

4719

## CERTIFICATE OF DEATH

04843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>525 Orchard Way</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Dora</i>		First	Middle	Last	4. DATE OF DEATH <i>April 8</i>	Month	Day	Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	B. DATE OF BIRTH <i>8/2/79</i>	9. AGE (in years last birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ASWF</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Locksmofer</i>		14. MOTHER'S MAIDEN NAME <i>Melissa Whittington</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Charles H. Smoot, 525 Orchard Way XXXXXX</i>		Address <i>Silver Spring, Maryland</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pneumococcal meningitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1007 P.M.</i>		20f. (City or town) <i>Prince George County</i>		(County) (State)
21. I certify that I attended the deceased from <i>April 5, 1958</i> to <i>April 8, 1958</i> that I last saw the deceased alive on <i>April 8, 1958</i> and that death occurred at <i>1007 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>M.D. 9301 Galesville Rd., Silver Spring, Md.</i>		DATE SIGNED <i>Apr. 9, 1958</i>		
ACTUAL SIGNATURE <i>Bennet A. Porter, Jr.</i>								
PHYSICIAN'S NAME (Type) <i>BENNET A. PORTER, JR.</i>								
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>April 11, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>PRINCE GEORGE COUNTY, MARYLAND</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey</i>		ADDRESS <i>8734 Galore St., Silver Spring, Md.</i>		REC'D BY REGISTRAR <i>APR 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Q. L. Seaman</i>		

BURZAY X-1

APR 11 1968

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

114844

FOR STATE  
HEALTH DEPT.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Reg. Dist. No.													
1. PLACE OF DEATH		4852		2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission)											
a. COUNTY		Montgomery		a. STATE <u>Canada</u> b. COUNTY <u>Ont.</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		N. Chey Chase		c. LENGTH OF STAY IN 1b <u>4½ days</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		3407 Inverness Dr		d. STREET ADDRESS <u>20 Blake St.</u>											
3. NAME OF DECEASED (Type or print)		First <u>Frank</u> Middle <u>Selviter</u>		Last <u>Spiera</u>		4. DATE OF DEATH		Month <u>Apr.</u> Day <u>10</u> Year <u>1958</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years less than today) <u>73 yrs</u>		f. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		g. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)											
<u>Dentist</u>		<u>Retired</u>		<u>Canada</u>											
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		13. CANADA									
NO		None		Jean Yalloway (daughter)		Address <u>Same as item 1</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>												<u>Sudden</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Barrie</u>		(County) <u> </u>		(State) <u> </u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>Apr. 10 1958</u>													
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans</u>		22b. DATE THEREOF <u>4/10/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <u>Barrie Cemetery</u>		22d. LOCATION (City, town, or county) <u>Barrie</u>		(State) <u>Ontario</u>							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>										24b. REGISTRAR'S SIGNATURE <u>W. eden</u>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4853 CERTIFICATE OF DEATH

Reg. Dist. No. 04845

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>106 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Peoria</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>1111 North Wood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Dorothy</b>	Middle <b>Jeanne</b>	Last <b>Stafford</b>	4. DATE OF DEATH <b>April 20,</b>	Month <b>April</b>	Day <b>20</b>	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 9, 1934</b>	9. AGE (in years lost birthday) <b>23</b> yrs	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Dwayne Pottorf</b>			14. MOTHER'S MAIDEN NAME <b>Maxine Slutz</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unascertainable</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Metastases</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Chorio Carcinoma</b> 8-10 mos DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Peoria</b> (County) <b>Illinois</b> (State) <b>Illinois</b>		
21. I certify that I attended the deceased from <b>January 1, 1958</b> , to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 20, 1958</b> , and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-20-58</b>								
ACTUAL SIGNATURE <b>Charles F. Nadler</b>		M.D. <b>Charles F. Nadler, M. D.</b>						
PHYSICIAN'S NAME (Type) <b>Charles F. Nadler, M. D.</b>		The Clinical Center National Institutes of Health Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4/21/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) <b>Peoria, Illinois</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John L. Martin</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4854

## CERTIFICATE OF DEATH

Reg. Dist. No.

04846

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				d. STREET ADDRESS 1207 Geranium St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JOHN	Middle DENNIS	Last STOCKTON	4. DATE OF DEATH	Month April 15 Year 1958
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1871	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher		10b. KIND OF BUSINESS OR INDUSTRY Ranch		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Meredith Stockton		14. MOTHER'S MAIDEN NAME Not Available			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Lorena S. Shumaker, (same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Heart Failure		INTERVAL BETWEEN ONSET AND DEATH two hours	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Auricular Fibrillation		10 Days	
{ DUE TO (b) DUE TO (c)		Coronary Occlusion		10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ April 3, 1958, to April 15, 1958, that I last saw the deceased alive on Apr 10, 1958, and that death occurred at 10:45 a.m. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Robert J. Thibadeau, M.D.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		Apr 15, 1958	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1958		22c. LOCATION (City, town, county) George Washington Cemetery Prince George Co. (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters, 254 Carroll St. N.W. Wash DC		ADDRESS 24a. REC'D. BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04847

## 4720 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Montgomery</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>26 1/2 Hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitorium &amp; Hospital</i>		d. STREET ADDRESS <i>Chevy Chase 4842 Bradley Blvd. Apt. 2</i>	
3. NAME OF DECEASED (Type or print) <i>Irving Edwin Strobel</i>		4. DATE OF DEATH Month <i>4</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-2-91</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Naval Architect Retired.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <i>D.C.</i>		11. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>George E. Strobel</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Ford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO.	
(Yet to be known)		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobes pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <i>Possible myocardial &amp; failure</i>			
DUE TO  (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
4720		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that I attended the deceased from <i>19.44</i> , to <i>4/13</i> , 1958, that I last saw the deceased alive on <i>4/13</i> , 1958, and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1600 Carroll Ave.</i>			
ACTUAL SIGNATURE <i>J. J. McNeill</i>		DATE SIGNED <i>4/14/58</i>	
PHYSICIAN'S NAME (Type) <i>W.F. McNeill</i>		M.D. <i>Takoma Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/17/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cem.</i>		22d. LOCATION (City, town, or county) <i>(State)</i> <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>APR 15 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>	

BUREAU V. S.

APR 15 1953

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RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4855

## CERTIFICATE OF DEATH

Reg. Dist. No.

04848

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb <b>46 Years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3601 Farragut St.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>3601 Farragut St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STELLA</b>		First <b>W.</b>	Middle <b>STUBBS</b>	Lost <b></b>	4. DATE OF DEATH <b>April 25,</b>	Month <b>Year</b> <b>1958</b>	Day <b></b>	Year <b></b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White n</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1865</b>	9. AGE (In years last birthday) <b>92</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	12. IF UNDER 24 HRS. Hours <b></b>	13. IF UNDER 24 HRS. Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Towanda, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Augustus Smith</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hardy</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter</b>		Address <b>3601 Farragut St.</b>			
				<b>Henrietta Styer</b>		<b>Kensington, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>									
DUE TO <i>Arteriosclerous Generalized</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Sent</i> (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1950</b>	20f. (City or town) <b>1958</b>	(County) <b></b>	(State) <b></b>			
21. I certify that I attended the deceased from <b>1950</b> , to <b>1958</b> , that I last saw the deceased alive on <b>4/25/58</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Kensington, Md.</b>									
DATE SIGNED <b>4-26-58</b>									
ACTUAL SIGNATURE <i>Samuel Allen</i>									
PHYSICIAN'S NAME (Type) <b>SAMUEL ALLEN</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Montgomery Co., Md.</b>			
(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>									
ADDRESS									
24a. REC'D BY REGISTRAR DATE <b>APR 28 '58</b>									
24b. REGISTRAR'S SIGNATURE <i>Clinch</i>									

TO HOSPITAL, 2a ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REVIEW

1959

REVIEW

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4856 CERTIFICATE OF DEATH

04849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>261 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Route 1, Box 351</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Stephen</b>	Middle <b>Lee</b>	Last <b>Swiger</b>	4. DATE OF DEATH <b>April 5 1958</b>	Month Day Year	Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1940</b>	9. AGE (In years lost birthday) <b>17 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Herbert R. Swiger</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Brissey</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>55x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <b>Hepat-kidney degeneration</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.                          p. m.                          19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 18, 1957</b> , to <b>April 5, 1958</b> , that I last saw the deceased alive on <b>April 5, 1958</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b>						DATE SIGNED	
ACTUAL SIGNATURE <b>Andrew S Engel</b>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMAT. ON, REMOVAL (Specify)		22b. DATE THEREOF <b>Serial April 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Katherine Donaldson</b>		ADDRESS <b>46-30 Laurel, Md.</b>		24a. REC'D. BY REGISTRAR DATE <b>APR 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K. S.

APR 9 1958

KIEGEVIE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4857

## CERTIFICATE OF DEATH

Reg. Dist. No.

04850

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg,</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg,</b>		d. STREET ADDRESS <b>/</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>SARAH</b>	Middle <b>ELLEN</b>	Last <b>THOMAS</b>	4. DATE OF DEATH <b>April 6, 1958</b>	Month <b>April</b>	Day <b>6</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1899</b>	9. AGE (In years less birthday) <b>58 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frederick Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Hall</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or date of service)		17. INFORMANT <b>Seymour Thomas (Husband) Dickerson, Md.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral-Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriesclerosis</b> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rt. Hemiparesis (Residual)</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Barnesville, Md.</b>		(County)	(State)	
21. I certify that I attended the deceased from <b>11 Oct., 1953</b> to <b>6 April., 1958</b> , that I last saw the deceased alive on <b>6 April., 1958</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b>								
DATE SIGNED <b>7 Apr. 58</b>								
MEDICAL CERTIFICATION								
ACTUAL SIGNATURE <b>Gordon W. Smith</b>								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/11/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert D. Shoultz</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>D. H. [Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 15 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 4858 CERTIFICATE OF DEATH

Reg. Dist. No.

04851

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5003 Cushing Drive</b>				d. STREET ADDRESS <b>5003 Cushing Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Julia</b>		First	Middle	Last	4. DATE OF DEATH <b>April 20, 1958</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1897</b>	9. AGE (in years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR <b>1 Months</b>	IF UNDER 24 HRS <b>6 Days</b>	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Edward Kingberger</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Lynch</b>			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edwin C. Thompson-same as 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>CARCINOMA OF THE STOMACH. (ADENOCARCINOMA)</b> . DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <b>16 months</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington, D.C.</b>		(County) <b>D.C.</b>	(State) <b>D.C.</b>
21. I certify that I attended the deceased from <b>Feb. 6, 1957</b> , to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 19, 1958</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>John F. Finnegan</b>									
DATE SIGNED <b>John F. Finnegan</b>									
ACTUAL SIGNATURE <b>John F. Finnegan</b>									
PHYSICIAN'S NAME (Type) <b>John F. Finnegan</b> 1746 "K" Street, N.W. Washington, D.C.									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. RECD. BY REGISTRAR DATE <b>APR 23 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John F. Finnegan</b>			

RECEIVED  
BUREAU Y.

APR 12 1933

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 04852

1. PLACE OF DEATH a. COUNTY		4721 Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE		b. COUNTY		
Takoma Park		DOA		Maryland		Columbia		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?		
Wash. San. + Hospital		Paradise Ave.		Md. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
William				Roscoe Thompson	4	-	7	- 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1YEAR	11. UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-21-1873	65 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Construction		Public Utility		Maryland		No		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
John M. Thompson		Amelia Condon		Yes		W.W. I		217-10-7747 Mrs. Pearl Thompson
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH		sudden
420.1		DUE TO		(b)		DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE		FRANK J. BROSCHEIT		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-7-58		
EXAMINER'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR Crematory		22d. LOCATION (City, town, or county) (State)		
Burial		4-10-1958		Pine Grove		Mt. airy Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
G. H. Haltz		Waukeech Md.		APR 10 '58		Allied Health		
VS. A15ME(5) 5M 9/55								

BURLAU V.

APR 10 1963

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4725

## CERTIFICATE OF DEATH

04853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERTHA</b>		First <b>M.</b>	Middle <b>TONNEMAN</b>
4. DATE OF DEATH <b>April 21 1958</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1892</b>
9. AGE (In years lost birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
10c. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH ANDRESKY</b>		14. MOTHER'S MAIDEN NAME <b>MARIE SUVA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-5381</b>	
17. INFORMANT <b>HARRY I. TONNEMAN</b>		Address <b>Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440 X</b>		<b>Pulmonary edema</b> 3 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<b>Congestive Heart failure</b> 8 weeks	
DUE TO (c)		<b>Hypertension cardiovascular disease 5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> 19 p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1953</b> , to <b>April 21, 1958</b> , that I last saw the deceased alive on <b>April 21, 1958</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8641 Colleville Road Silver Spring, Md.</b>	
ACTUAL SIGNATURE <b>Ralph E. Patten M.D.</b>		DATE SIGNED <b>4/21/58</b>	
PHYSICIAN'S NAME (Type) <b>RALPH E. PATTEN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-25-58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Collins</b>		24a. REC'D BY REGISTRAR <b>APR 24 '58</b>	
ADDRESS <b>Francis J. Collins 3821 14th St. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be returned by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 24 1966

REFUGEE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If  "delay" is necessary, please execute it/certificate, writing the word "pending" in pencil in Item 18. Give  1, 2, and  3 to the  Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNER. DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14854

Reg. Dist. No.

4859

## 1. PLACE OF DEATH

## b. COUNTY

Montgomery

MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gaithersburg

## c. LENGTH OF STAY IN lb

40 yrs

## d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

51 W. Diamond Ave

3. NAME OF  
DECEASED  
(Type or print)

First Alvin

Middle

Trevey

Last

## 4. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED 

b.

NEVER

## 8. DATE OF BIRTH

WIDOWED DIVORCED 

Apr. 5, 1880

77

yrs

BUREAU Y. S.

APR 22 1962

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4860 CERTIFICATE OF DEATH

04855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>5033 Alta Vista Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD</b>		First	Middle	Lost	4. DATE OF DEATH Month	Day	Year
		<b>E.</b>	<b>UPPERMAN</b>		<b>April</b>	<b>6</b>	<b>1958</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/06</b>	9. AGE (In years last birthday) <b>51</b>	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>24</b>		11. IF UNDER 24 HRS Hours <b>24</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Budget Officer U.S. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington D.C.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Malcolm W. Upperman</i>		14. MOTHER'S MAIDEN NAME <i>Fox, Mary D.</i>		Address <i>Bethesda</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Anna E. Upperman 5033 Alta Vista Rd.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary occlusion</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> , 19, to <b>Apr. 6</b> , 1958, that I last saw the deceased alive on <b>Apr. 6</b> , 1958, and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Malcolm D. Harrison M.D. 4535 Yuma St NW</b>							
DATE SIGNED <b>Malcolm D. Harrison Wash 16 DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Fulphrey Bethesda, Maryland</b>							
ADDRESS				24a. REC'D BY REGISTRAR DATE <b>APR 8 '58</b>			
				24b. REGISTRAR'S SIGNATURE <b>C. Schaefer</b>			

BUREAU V. S.

APR 0 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4861 CERTIFICATE OF DEATH

04856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>5013 Strathmore Ave.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5013 Strathmore Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>CHARLES E. WARFIELD</b>		First	Middle	Last	4. DATE OF DEATH <b>April 18, 1958</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 14, 1884</b>	9. AGE (In years lost birthday) <b>73 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Acct. B &amp; O R.R. - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S</b>		
13. FATHER'S NAME <b>J. Latimer Warfiled</b>		14. MOTHER'S MAIDEN NAME <b>Annie Lewis</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Sister Edith W. Tabler</b>		Address <b>Item #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple myeloma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Mar. 14, 1955 to April 18, 1958</b> , that I last saw the deceased alive on <b>April 17, 1958</b> , and that death occurred at <b>12:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Robert N. Coale M.D. 4630 Montgomery Ave. Bethesda, Md.</b>								
DATE SIGNED <b>4/18/58</b>								
ACTUAL SIGNATURE <b>ROBERT N. COALE</b>								
PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>		22d. LOCATION (City, town, or county) <b>Hyattstown, Maryland</b>						
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. DATE THEREOF <b>4/19/58</b>		22g. NAME OF CEMETERY OR CREMATORIUM <b>Hyattstown Cemetery</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Redden</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4862 CERTIFICATE OF DEATH

04857

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Adrian</b>		First <b>D.</b>	Middle <b>Waring</b>
4. DATE OF DEATH <b>April 1 1958</b>	Month <b>April</b>	Day <b>1</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/85</b>
9. AGE (in years lost birthday) <b>72 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Ins.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	11. BIRTHPLACE (State or foreign country) <b>New YORK</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>James Duncan Waring</b>		14. MOTHER'S MAIDEN NAME <b>Josephine LAFINNE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Wife</b>		Address <b>(Same as above)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction, antero-lateral wall</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis, advanced</b> DUE TO (c) <b>Generalised arterio sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>1 yr +</b> <b>10 yrs +</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Recent Suprapubic Prostatectomy (6 wks) for Prostatism</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-26-1958</b> to <b>April 1, 1958</b> , that I last saw the deceased alive on <b>April 1, 1958</b> , and that death occurred at <b>153 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Stewart Clapp</b> ADDRESS (Street, city or town, state) <b>3921 Ingman St.</b> DATE SIGNED <b>4-2-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4/3/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn</b>
22d. LOCATION (City, town, or county) <b>Nocterville Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Beaufay - Elly - Bethesda Md</b>		ADDRESS <b>Elly - Bethesda - Md</b>	24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Asst. Queen</b>

BUREAU V.

APR 7 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4863 CERTIFICATE OF DEATH

04858

Reg. Dist. No. 215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Arlington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>2000 4th Street South</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Emily</b>		First <b>Emily</b>	Middle <b>Anne</b>	Last <b>WEINBECK</b>	4. DATE OF DEATH <b>April 9 1958</b>	Month <b>April</b>	Day <b>9</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-58</b>	9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Leo William WEINBECK</b>				14. MOTHER'S MAIDEN NAME <b>Arliss Maxine DOROFF</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Father) Leo W. Weinbeck, same as #2 above</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Asphyxia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> <b>2 day</b> (c) <b></b>								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 7, 1958</b> , to <b>April 9, 1958</b> , that I last saw the deceased alive on <b>April 8, 1958</b> , and that death occurred at <b>12:30A.M.</b> , from the causes and on the date stated above								
ACTUAL SIGNATURE <i>Kenneth W. Sell</i>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-9-58</b>						
PHYSICIAN'S NAME (Type) <b>K. W. SELL, LT, MC, USN</b>		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-14-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. L. Pumphrey Funeral Home, 7557 Wisconsin Ave</i>		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR <b>APR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Allie's assis</i>		
VS A15 (4) 1SM 10/57								

BURLAU V. S.

APR 11 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4722 CERTIFICATE OF DEATH

Reg. Dist. No.

04859

1		M		75		I			
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.							
1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE		New York		b. COUNTY	
Montgomery		MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Albany			
Takoma Park		56 days		d. STREET ADDRESS		511 Bradford St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington San & Hosp.		4. DATE OF DEATH		Month April		Day 15 Year 1958	
3. NAME OF DECEASED (Type or print)		First	Middle	Last					
Margaret				Weir					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH		9. AGE (In years lost birthday) 72 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
F		White		4-29-85		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Secretary				New York		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Choucey Weir		Martha Moyer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		Address			
				Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Macular Uveitis		Eubalensis		67 days			
539.1 DUE TO		Mediastinal & pleural inflammation				2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)							
		DUE TO		(c) Sinusitis		2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		-		-		-		19. WAS AUTOPSY PERFORMED?	
-		-		-		-		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-20, 1958, to 4-15, 1958, that I last saw the deceased alive on 4-15, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above.									
						ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		John J. Baccus, M.D.		7602 Carroll St. - in 100-104					
PHYSICIAN'S NAME (Type)		John J. Baccus, M.D.		7602 Carroll St. - in 100-104					
22a. BURIAL, CREMATION, REMOVAL (If any)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Transit Burial		April 14, 1958		Brooklyn Cemetery		Brooklyn		New York	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Arthur Walters		254 Carroll St. N.W.		APR 17 58		April 17 58			

BUREAU X-14

APR 17 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

4864

## CERTIFICATE OF DEATH

Reg. Dist. No.

04860

1. PLACE OF DEATH a. COUNTY	Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
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b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	d. STATE	D.C.
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d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	Bethesda Suburban		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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3. NAME OF DECEASED (Type or print)	First Joseph	Middle Franklin	Last Whalen	4. DATE OF DEATH	Month 4	Day 17	Year 1958
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5. SEX Male	COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 25 1882	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
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Farmer	Farming	Maryland	U.S.A.
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13. FATHER'S NAME Henry Whalen	14. MOTHER'S MAIDEN NAME Elizabeth E. Ward
--------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address 4000 Blockhouse St
--	-------------------------	---------------	----------------------------

No	Unknown	MRS. Edna W. Warner - Daughter Chevy Chase
----	---------	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
---	----------------------------------

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arterosclerotic Cardiovascular Disease	20 yrs
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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
--	--	--

(b)	Generalized arterosclerosis	10 yrs
-----	-----------------------------	--------

DUE TO		
--------	--	--

(c)		
-----	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	---

Diabetes mellitus (2) fracture right hip
--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--	--

20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D. C.	(County)	(State)
--	--	--	---------------------------------------	----------	---------

21. I certify that I attended the deceased from 3/28 1958 to 4-17-1958, that I last saw the deceased alive on 4-16-1958, and that death occurred at 503 P.M. from the causes and on the date stated above.
--

ACTUAL SIGNATURE C. Roger Kurtz M.D.	ADDRESS (Street, city or town, state) 3700 Rockville Pike, Bethesda, MD	DATE SIGNED 4-17-58
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PHYSICIAN'S NAME (Type)	
-------------------------	--

22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22e. DATE THEREOF 4/19/58	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery	22d. LOCATION (City, town, or county) Washington, D. C.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Humphrey	ADDRESS Bethesda, Maryland	24o. REC'D BY REGISTRAR APR 21 '58	24b. REGISTRAR'S SIGNATURE Alice L. French
---	----------------------------	------------------------------------	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1953

SEARCHED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4865 CERTIFICATE OF DEATH

Reg. Dist. No.

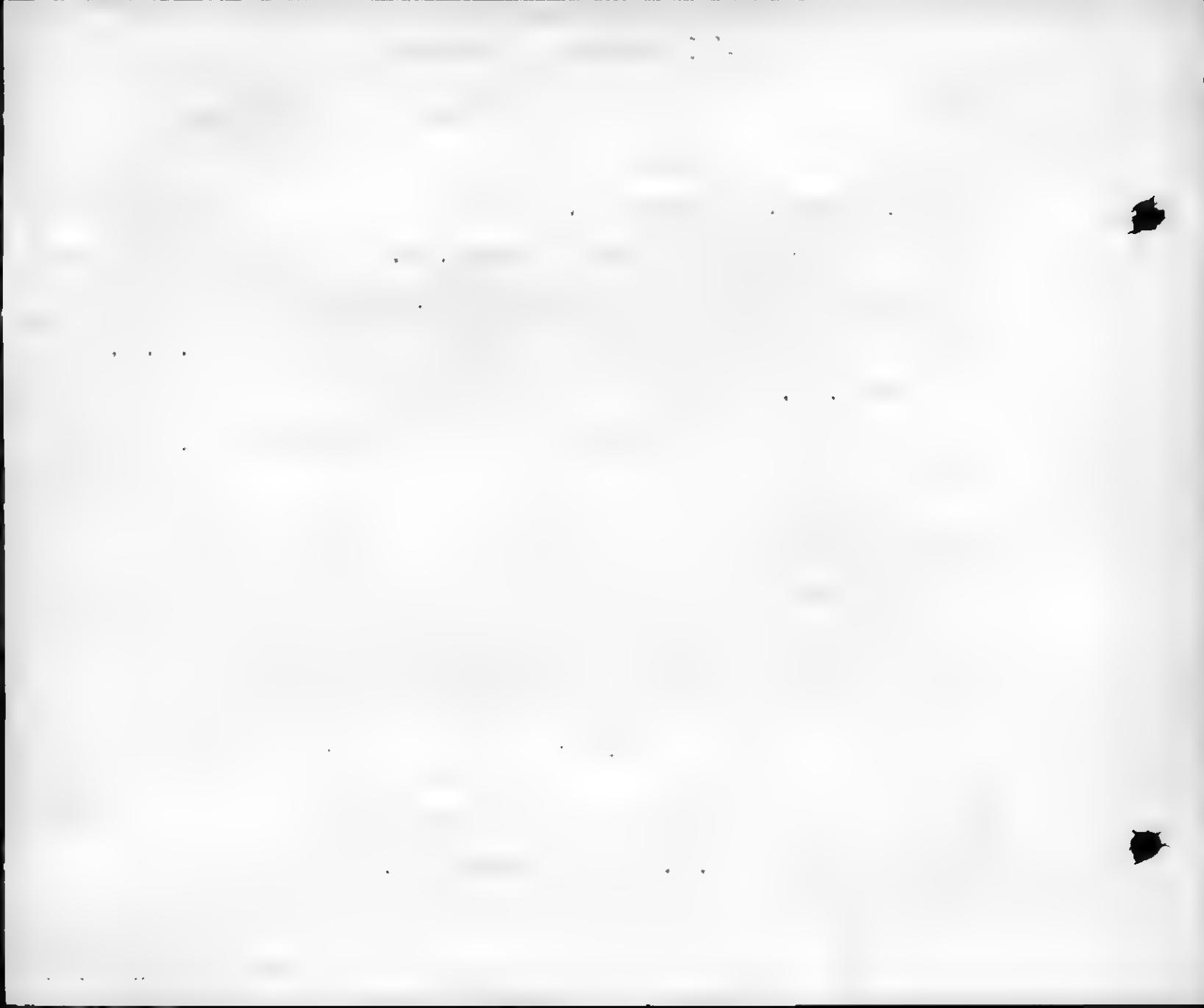
04861

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE <b>Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>36 days</b>	d. STREET ADDRESS <b>RFD #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>							
3. NAME OF DECEASED (Type or print)	First <b>Cecil</b>	Middle <b>Howe</b>	Last <b>Wheatley, Jr.</b>	4. DATE OF DEATH <b>April 29, 1958</b>	Month <b>April</b>	Day <b>29</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 8, 1925</b>	9. AGE (In years lost birthday) <b>32 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Cecil Wheatley, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Carroll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>713-42-7055</b>		17. INFORMANT The Medical Record Address <b>Unavailable</b> The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<b>Subarachnial Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH			
		<b>Acute myelocytic Leukemia</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 24, 1958</b> to <b>April 29, 1958</b> , that I last saw the deceased alive on <b>April 29, 1958</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Roger Lester</i> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) <b>Federalsburg, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 6 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Albert L. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 10/57



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04862

Reg. Dist. No.

**4866**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda	10 min.	X Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Suburban Hosp		5915 Conway Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Esther	Middle Aileen	Last Wheeler
4. DATE OF DEATH	Month Apr. 3	Year 1958	Day 19
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	8. AGE (In years last birthday) 12/26/1910 47 yrs.
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Purchasing agent N.N.		Med. Center	Wis.
12. CITIZEN OF WHAT COUNTRY?		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John B. Litney		Mary E. Pope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		Unknown	Hosp. Record
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral destruction			
DUE TO			
(b) subdural and dissecting hematoma			
DUE TO			
(c) ruptured aneurysm, left mid-cerebral artery			
INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 4, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart			
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58	
22c. NAME OF CEMETERY OR CREMATORIALY Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Bethesda, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE <i>Alister Lee</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
 SM 9/55

BURZAU Y. S.

APR 7 1960

MCGEHEE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4867 CERTIFICATE OF DEATH

Reg. Dist. No. 04863

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>5811 Maiden Lane</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5811 Maiden Lane</b>				e. STREET ADDRESS <b>5811 Maiden Lane</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ETHEL</b>		First	Middle	Last	4. DATE OF DEATH <b>WILLIAMS</b>	Month	Doy	Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1883</b>	9. AGE (In years less birthday) <b>74</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>				
13. FATHER'S NAME <b>Frank Gray</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anne Brawner</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Walter M. Williams-same as above</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.										
(b) <i>Generalized Coecinomatosis 2 years</i>										
(c) <i>Adenocarcinoma of Breast 6 months</i>										
INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Nov. 1956, to April 28 1958</b>		(County)	(State)	
21. I certify that I attended the deceased from <b>Nov. 1956, to April 28 1958</b> , that I last saw the deceased alive on <b>4/28 1958</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>James T. Burns</i> M.D. <b>915-19th St. NW, D.C.</b> ADDRESS (Street, city or town, state)										
PHYSICIAN'S NAME (Type) <b>JAMES T. BURNS M.D. Wash D.C.</b> DATE SIGNED <b>May 1 1958</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use of the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4868 CERTIFICATE OF DEATH

04864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Derwood</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <b>Elmer</b>	Middle <b>Norris</b>	Last <b>Windsor</b>	4. DATE OF DEATH <b>April 25</b>	Month <b>Day</b>	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1.18.02</b>	9. AGE (In years lost birthday) <b>56 yrs.</b>	10. IF UNDER 1 YEAR Months <b>Days</b>	11. IF UNDER 24 HRS. Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY/ <b>U.S.A.</b>						
13. FATHER'S NAME <b>Doras Windsor</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Brady</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with metastases</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>				
151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>lung abscess, left lower lobe</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>lung abscess, left lower lobe</b>										
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Derwood</b>		(County)	(State)			
21. I certify that I attended the deceased from <b>4/25/58</b> to <b>4/25/58</b> that I last saw the deceased alive on <b>4/25/58</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>				
ACTUAL SIGNATURE <i>Arthur Woodward</i>		DATE SIGNED <b>4/25/58</b>										
PHYSICIAN'S NAME (Type) <b>A. F. Woodward, M. D., Rockville, Md.</b>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-1-68</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Tidman Cemetery</b>		22d. LOCATION (City, town or county) <b>Derwood</b>		(State) <b>Tal</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gathings</i>		ADDRESS <b>Gathings, Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 1 '58</b>		24b. REGISTRAR'S SIGNATURE <i>W.B. Schuck</i>						
VS A15 (4) 15M 9/55												



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4869

## CERTIFICATE OF DEATH

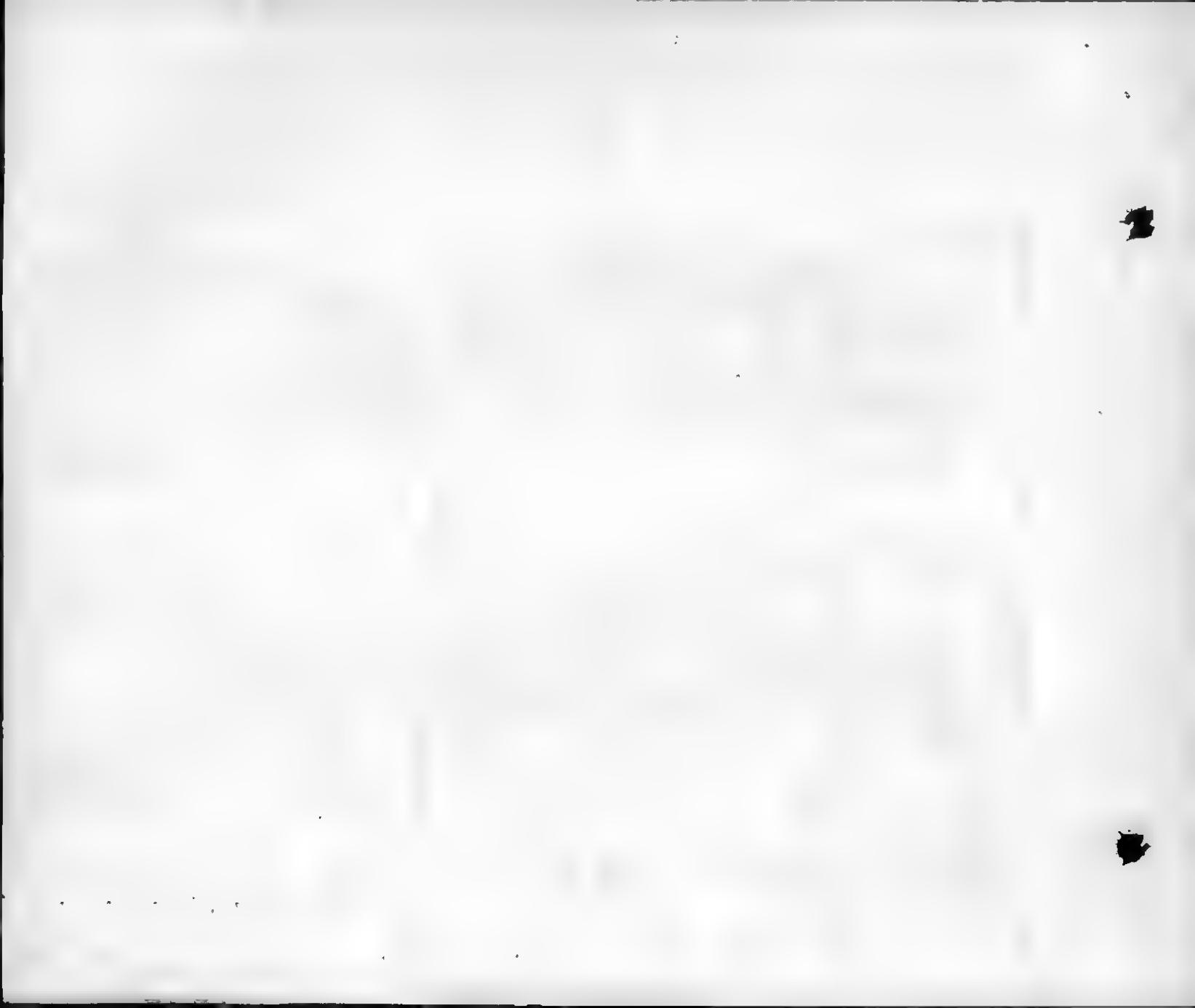
Reg. Dist. No.

04865

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>MARYLAND</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>4 days</i>	b. COUNTY <i>Maryland</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL (If not an hospital, give street address) OR INSTITUTION <i>Suburbans</i>	d. STREET ADDRESS <i>10201 Meredith Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Sybelle Alberta Wolfe</i>	First <i>Sybelle</i>	Middle <i>Alberta</i>	Last <i>Wolfe</i>	4. DATE OF DEATH <i>14 29 1958</i>	Month <i>14</i>	Day <i>29</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 16 1881</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Elisha E. Mullinix</i>		14. MOTHER'S MAIDEN NAME <i>Mary Rose Darling</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Daughter</i>		Address <i>Mary Wolfe Miller 10306 Brunswick Ave.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>455.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>						
(b) DUE TO Right cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>						
(c) DUE TO Atrial fibrillation		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>4 PM</i> , to <i>4 PM</i> , <i>1958</i> , that I last saw the deceased alive on <i>April 29, 1958</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>C. Roger Hurtz</i>		ADDRESS (Street, city or town, state) <i>M.D. 361 Conoco Rd. Silver Spring, Md.</i>		DATE SIGNED <i>4/29/58</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5/3/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. JOHN'S CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>Silver Spring, - Mont. Co. Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren &amp; Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Warren &amp; Humphrey</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04866

## 4870 CERTIFICATE OF DEATH

Reg. Dist. No. XX 215

1. PLACE OF DEATH a. COUNTY <b>Maryland Montgomery MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. STREET ADDRESS <b>718 "C" Street, S.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Emile</b>		First <b>"X"</b>	Middle <b>WUNDERLICH</b>
4. SEX <b>Female</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. DATE OF BIRTH <b>30 Sept. 1869</b>
8. AGE (in years last birthday) <b>88</b>	9. IF UNDER 1 YEAR yrs. <b>Months</b>	10. IF UNDER 24 HRS. Hours <b>Days</b>	11. IF UNDER 24 HRS. Min. <b>Year</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Housewife)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>Gotlieb SEMMLER</b>		14. MOTHER'S MAIDEN NAME <b>Marie WARTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Friend) Mrs. Helene A. Au,</b>		Address <b>S.E. Wash.D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Elbeck</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <b>myocardial infarction</b>		12 hours	
(c) DUE TO <b>atherosclerotic heart disease</b>		1/2 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture left femur - 7 days postoperative</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down while left femur potts</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>904.0</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. CITY OR TOWN (County) <b>Washington, D. C.</b>		(State)	
21. I certify that I attended the deceased from <b>14 April</b> , 19 <b>58</b> , to <b>22 April</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>22 April</b> , 19 <b>58</b> , and that death occurred at <b>11:00P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. U.S. Naval Hospital, Bethesda, Md.</b>			
DATE SIGNED <b>4-23-58</b>			
SIGNATURE <b>N. Thomas Debevoise</b>			
PHYSICIAN'S NAME (Type) <b>N. Thomas Debevoise, LT, MC, USN</b> U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>25 Apr. 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>	
24a. FUNERAL DIRECTOR'S SIGNATURE <b>Joyce Wachler</b>		ADDRESS <b>Lee, 4th &amp; Mass Ave., N.W. Washington, D.C.</b>	
24b. REC'D BY REGISTRAR <b>APR 30 '58</b>		24c. REGISTRAR'S SIGNATURE <b>G. Lees</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

REGISTRAR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

בָּנָן V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4871

## CERTIFICATE OF DEATH

Reg. Dist. No.

04867

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>New Jersey</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Md.</b>		c. LENGTH OF STAY IN lb <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garwood</b>		d. STREET ADDRESS <b>532 Fourth Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Diane</b>		First <b>Diane</b>	Middle <b>(none)</b>	Last <b>Yankow</b>	4. DATE OF DEATH <b>April 23, 1958</b>	Month <b>April</b>	Day <b>23</b>	Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1954</b>	9. AGE (In years last birthday) <b>3 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>	13. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Walter N. Yankow</b>		14. MOTHER'S MAIDEN NAME <b>Joan Schmelz</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Atelectasis and Hemorrhage</b> DUE TO <b>754.2</b>						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Cardiac Surgery</b>						<b>24 hours</b>			
(c) DUE TO <b>Ventricular Septal Defect</b>						<b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>The Clinical Center</b>		(County) <b>National Institutes of Health</b>	(State) <b>Bethesda 14, Maryland</b>
21. I certify that I attended the deceased from <b>April 6, 1958</b> , to <b>April 23, 1958</b> , that I last saw the deceased alive on <b>April 23, 1958</b> , and that death occurred at <b>12:22 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Louis Gillespie, Jr.</b>		M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>4/23/58</b>			
PHYSICIAN'S NAME (Type) <b>Louis Gillespie, Jr., M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) <b>Westfield, New Jersey</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>7557 Wisc. Ave. Beth</b>		24a. REC'D. BY REGISTRAR DATE <b>APR 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Gedick</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

APR 25 1958

BUREAU V. S.

APR 25 1958

RECEIVED  
APR 25 1958  
DETROIT STATE POLICEOCTOBER 20 1958 100-28152-1  
RECEIVED A COPY OF THIS REPORT WAS MADE  
TO THE BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4872 CERTIFICATE OF DEATH

Reg. Dist. No.

04868

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>7103-2</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN lb <b>4½ yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>241 S. Prospect St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>BERTHA</b>		First	Middle	- Lost	4. DATE OF DEATH <b>April</b>	Month	Day	Year <b>20 1958</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1861</b>	9. AGE (In years lost birthday) <b>97 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Sharpsburg, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Capt. R. C. Bamford</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Atkins</b>			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Asbury Methodist Home, Gaithersburg, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <i>congestive heart failure, acute</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>pericarditis</i> <b>16 days</b> (c) <i>hypertension, cardiovascular disease</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>492X</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>4208 Anthony St</b> <b>Kensington</b> <b>Md</b> <b>42035</b>		(State)
21. I certify that I attended the deceased from <b>5-2</b> , 1956, to <b>4-16</b> , 1958, that I last saw the deceased alive on <b>4-16</b> , 1958, and that death occurred at <b>11:25 P.M.</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		ADDRESS (Street, city or town, state) <b>4208 Anthony St</b> <b>Kensington</b> <b>Md</b> <b>42035</b>						
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover</b>		DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quinton</b>		

WIRELESS TELEGRAM - GOVERNMENT OF INDIA - RECEIVED

4253 CERTIFICATE OF DEATH

APR 23 1958

BUREAU X-5  
RECEIVED